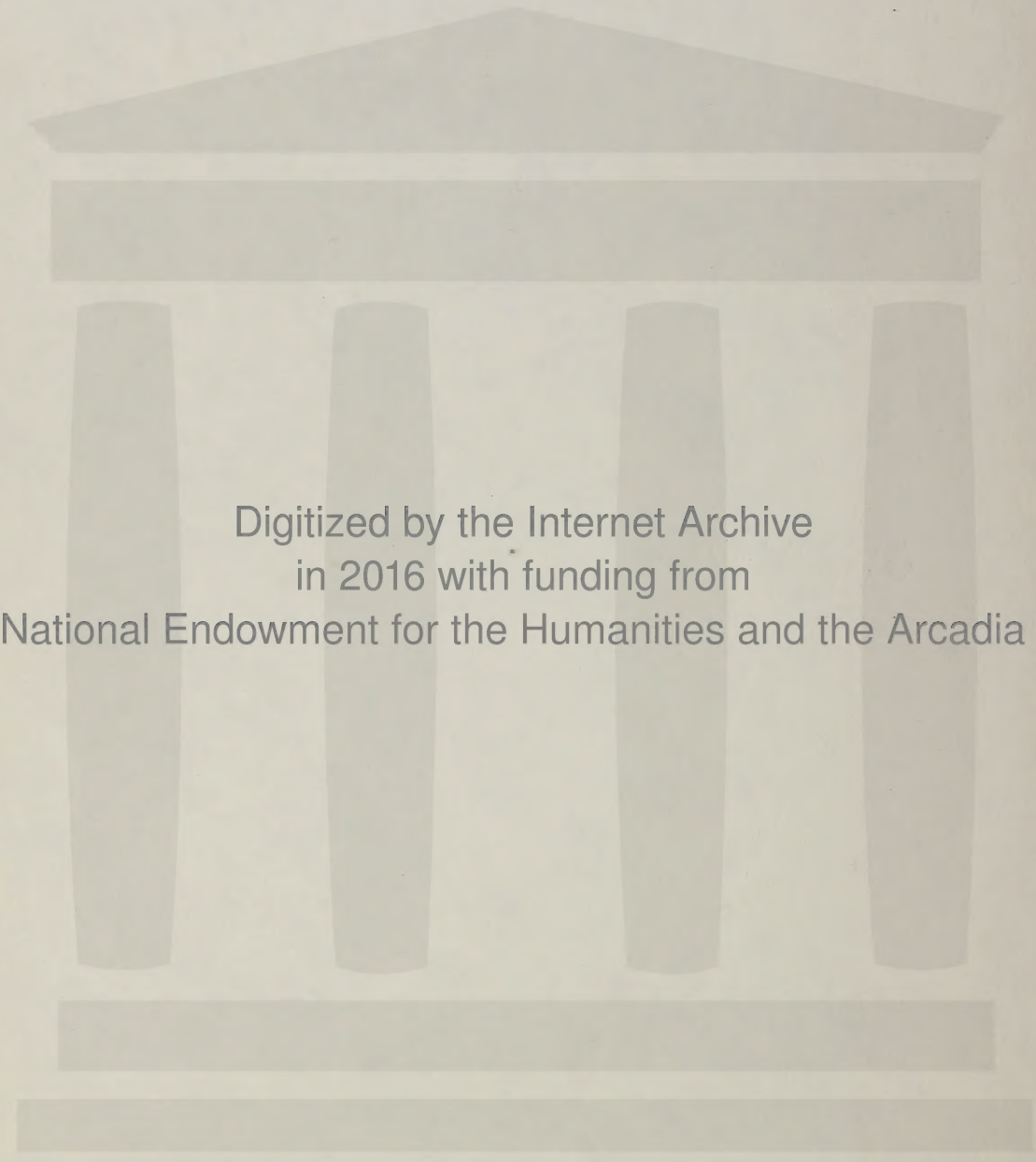
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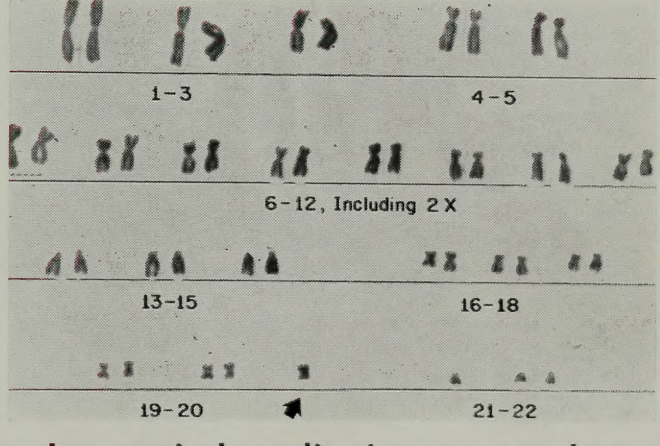
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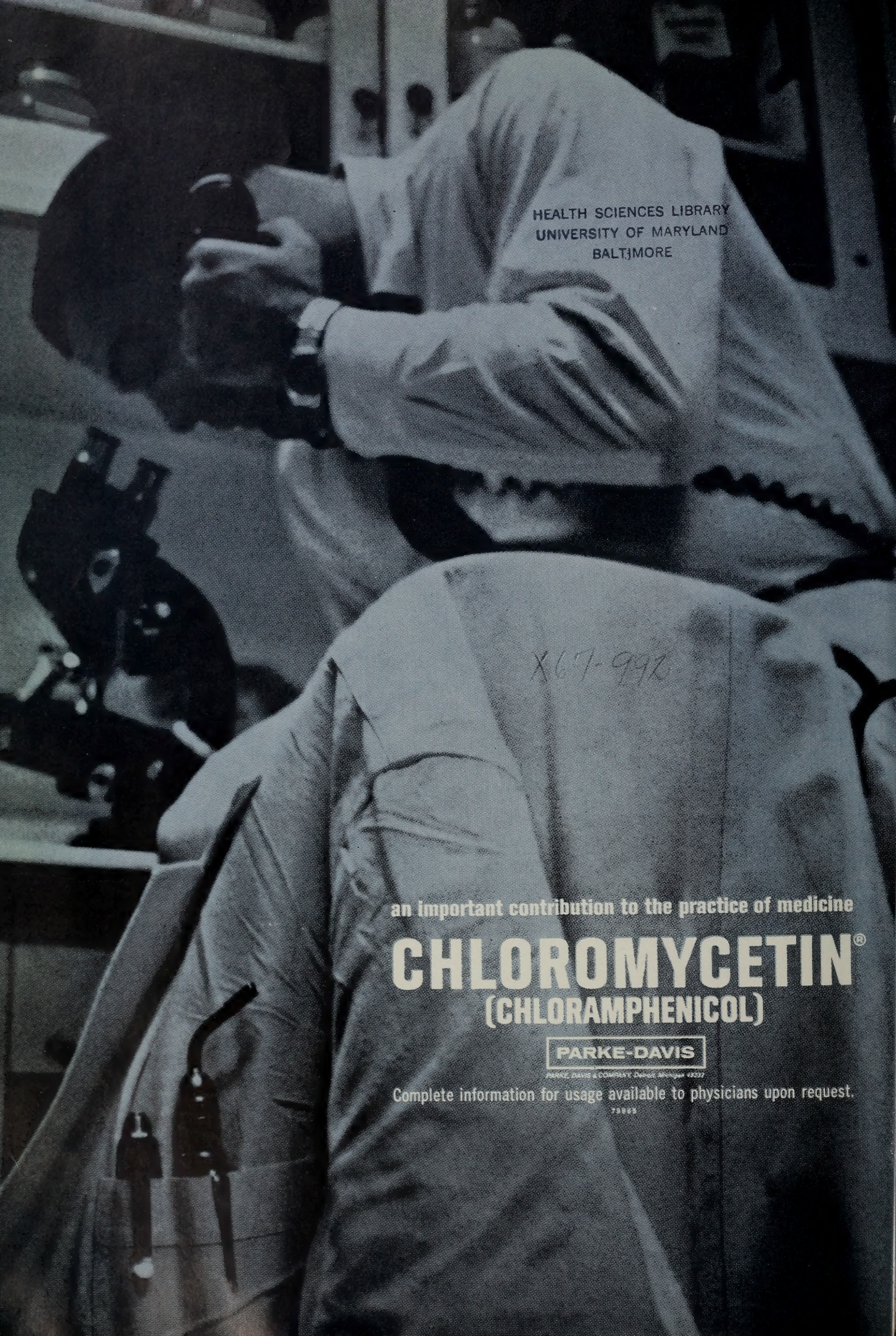
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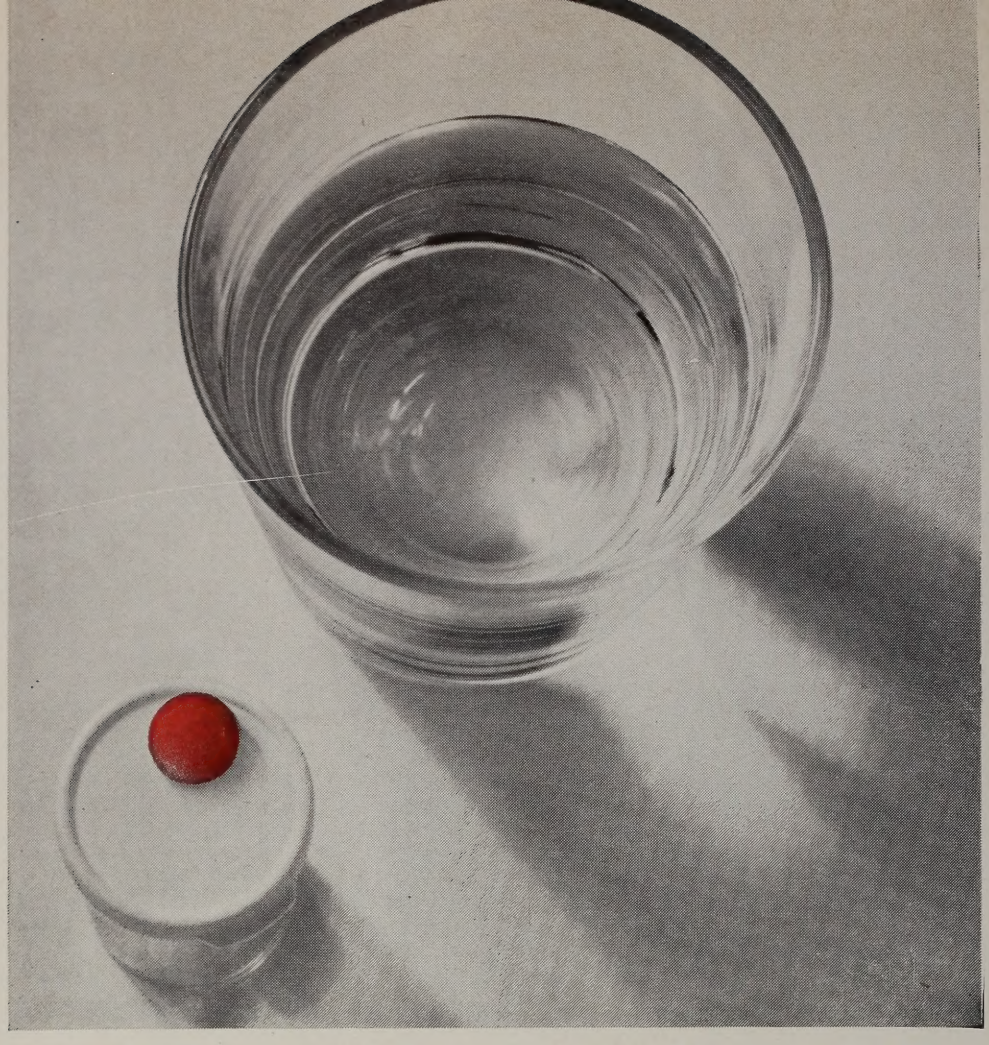
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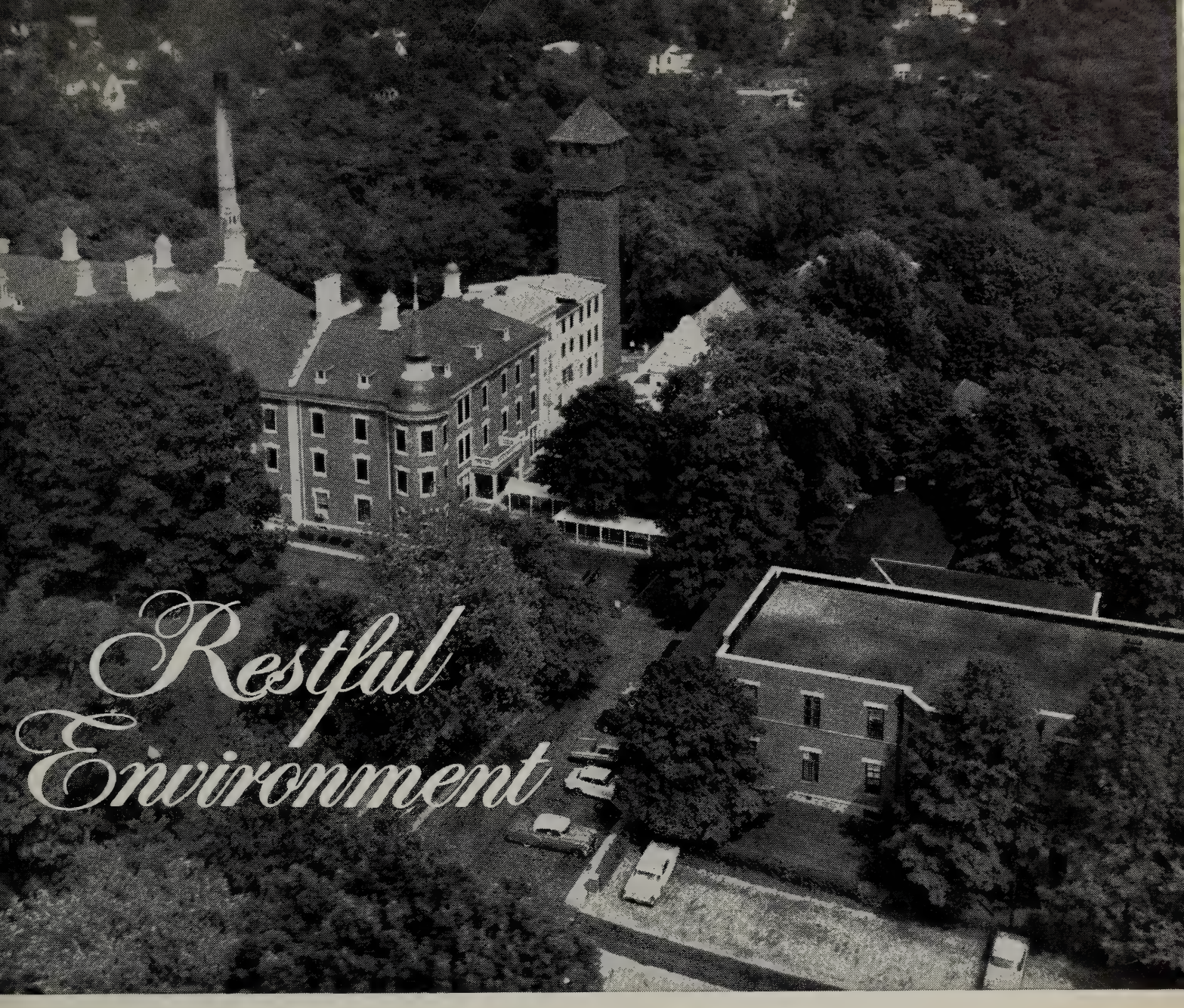
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Yellow Fever in Ohio

N. PAUL HUDSON, Ph. D., M. D.*

PART II

(Continued from December Issue)

THE appearance of yellow fever in Gallipolis was dramatically associated with the famous steamboat, *John A. Porter,* and its several barges. As the flotilla pushed its way upstream, it gained its reputation for evil which reached its lethal crisis at Gallipolis. In spite of quarantine, fumigation, burning of tar, segregation, medical assistance and flight, the towboat itself and then the town and community were visited by an epidemic of terrifying proportions (Frazier[5] and Sibley[6]). Figures in the literature on the number of cases and deaths vary greatly, depending apparently on whether the account was limited in time or was inclusive in respect to the boats, village and county; from 17 to 51 cases and 2 to 51 deaths are recorded by various writers. The population of Gallipolis at that time numbered 3700.

TABLE 1. *Yellow Fever in Ohio*

Year	Place	Source of Infection	Reported Cases	No. of Deaths
1871	Cincinnati	Natchez	1	1
1873	Cincinnati	Memphis	1	1
		"outside"	2	2
1878	Cincinnati	Ohio River docks	2	2
		Memphis	13	7
		New Orleans	3	2
		South of Ohio River	3	1
		Gallipolis	1	1
		steamboats	13	4
	Gallipolis	towboat and barges	17-51*	2-51*
	Pomeroy	" " "	7	2
	Aberdeen	" " "	8	5
	Brown County	Memphis	1	1
	Dayton	"all refugees from the South"	"some few cases"	1

*Various figures recorded, depending apparently on whether cases and deaths in Gallia County and on boats were included.

The other cases in Ohio in that fateful year were in Pomeroy (7) and Aberdeen (8) apparently from exposure to towboats and barges tied up at the shore, and in Brown County (1) and Dayton "some few cases"— the patients being refugees from Memphis and the South. Among these patients there were nine deaths reported.

Table 1 gives a summary of the reported number of cases and deaths and the presumed sources of infection.

Discussion

The incidence of yellow fever in Ohio in the 1870's can only be estimated. Data on the number of deaths may be fairly reliable, except possibly for some duplication among various recorders. The reported number of fatal cases totaled 81, perhaps 75 actually. If we assume a case-fatality rate of 40 per cent, we could estimate that there were about 190 cases in all. A maximum of something over 100 cases was recorded, and, although the discrepancy in numbers is marked, we are inclined to accept the larger figure as reflecting the case-fatality rate of that epidemic, with the recognition that we are dealing here with relatively small numbers, possible errors in diagnosis, and perhaps incomplete reporting.

Before the scientific era of experimentation in yellow fever was introduced by the U. S. Army Commission (Walter Reed, et al.) in 1900, there was much confusion regarding the conditions associated with the transmission of the disease. If an attendant or visitor of a yellow fever patient contracted the illness, contagion was considered to be the controlling factor. If, on the other hand, a nurse or a member of the patient's family remained healthy, contagion was not thought to be involved and common factors such as filth, bad air or vegetable decomposition were operating. The introduction of the disease to a community from a steamboat in spite of rigid personal quarantine argued against contagion, and cargo from the suspected vessel, especially if despicable such as rags or rotting freight, was incriminated. Confusion in medical judgment and in control for public protection naturally resulted from ignorance of the essential factors. If those responsible could only have put the mosquito into the equation, conflicts could have been reconciled and effective measures of control applied. But such was not to be the case until Reed and his associates confirmed the theory of mosquito transmission proposed earlier by Finlay, the Cuban doctor.

Whether yellow fever could be "engendered" and sustained in Ohio were considered important questions in the last century. We can now say that its occurrence depended on introduction and its persist-

*Dr. Hudson, Columbus, is Professor Emeritus of Microbiology, The Ohio State University College of Medicine; 1963-1964 President of Ohio Academy of Medical History; former service (1927-1930) with Rockefeller Foundation, yellow fever research, West Africa and Rockefeller Institute.

Read at the annual meeting of the Ohio Academy of Medical History, held in Columbus, Ohio, on May 9, 1965.

ence on the presence of the *Aedes* mosquito. Southern Ohio is not now within the zone of *Aedes aegypti* prevalence, but the assumption is reasonable that plenty of opportunity for its importation to the region was provided by fresh water containers and by bilge water in vessels plying the rivers from the South. On the other hand, we find no firm evidence that secondary tertiary cases, dependent on mosquitoes, occurred in Ohio. Even in the Gallipolis community the 35 or 40 ill could have been bitten by mosquitoes from the *John A. Porter* and its barges; nevertheless, the interval between the arrival of the towboat and heaven-sent frost (August 17 to October 17) could have allowed at least a few secondary cases from those first infected. Certainly, the history of 31 yellow fever cases among the crew on the infamous towboat and its barges from Louisiana on July 19 to Gallipolis on September 3 speaks for the perpetuation of a small but classical man - mosquito - man epidemic on board.

Why this disease should occur only in the three years mentioned is a puzzling question, when steamboat commerce began long before the 1870's and increased greatly during the subsequent 25 years before measures for control were known and the malady disappeared from the southern states and along the Mississippi River. One can only assume that yellow fever was subject to factors less conspicuous than the mosquito, or that only rarely did a virus strain appear capable of breaking through natural barriers and instituting disease.

Summary

Yellow fever occurred between 1871 and 1878 in six communities in Ohio, mostly along the Ohio River, with the largest numbers of cases in Cincinnati and Gallipolis. Records of incidence are incomplete and inconsistent, and only an estimation can be made that there were probably as many as 190 cases and 75 deaths. These figures include victims among the crews of towboats and their barges in Ohio waters.

It is doubtful that the disease was ever established in Ohio with secondary and tertiary cases after introduction, because of limited time between its appearance in the Summer and inactivation of the mosquito by frost, although a few secondary cases could have developed in Gallipolis in 1878.

Persons who became ill of yellow fever were refugees from epidemics in the South who were infected before their departure, passengers and members of crews of steamboats infected on board, persons ashore exposed to incriminated towboats and barges, and laborers on Ohio River docks. Thus conditions of transportation and commerce made possible the existence of this malady in a northern state.

With the role of the mosquito in transmission then unknown, many measures intended to control the disease proved ineffective and much medical and public confusion prevailed.

In spite of the fact that knowledge essential to prevent the spread of yellow fever was not available until the turn of the century, no further visitation of Ohio has taken place since frost in October 1878.

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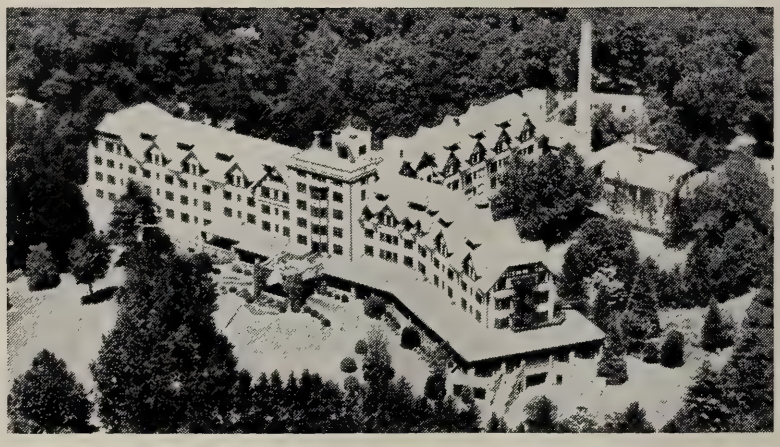
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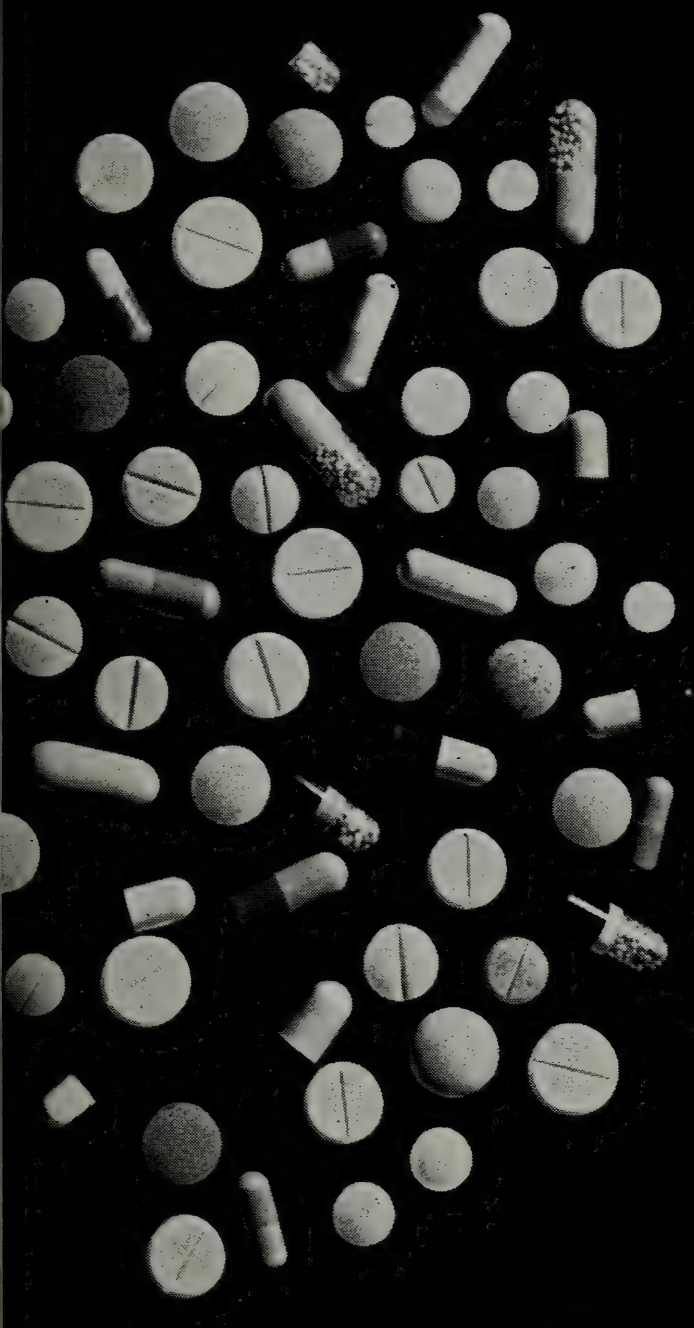
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OSMA Campaign Directed to the Public Will Stress The Importance of Immunization Against Measles

THE Ohio State Medical Association is about to conduct an Educational Campaign, directed to the general public, to make parents aware of the fact that measles is a preventable disease and that they should contact their physicians for the immunization. This campaign, starting in mid-January, will consist of about six weekly news releases to be prepared by the OSMA staff for local newspapers, spot announcements for radio and television stations, and posters to be displayed in physicians' offices and appropriate public places.

In view of the role Ohio physicians will play in this campaign, the Subcommittee on Measles Immunizations, OSMA School Committee, prepared as guidelines the following information and recommendations, which were approved by The Council. Members of the Subcommittee are Charles H. McMullen, M. D., Chairman; Thomas E. Shaffer, M. D., and Carl L. Petersilege, M. D.

To have an effective tool and not use it is an error of omission as serious as a wrong diagnosis. "The development period of measles vaccine is now over and measles vaccine should be administered routinely to all children without a history of clinical measles or measles vaccination." This statement is quoted from the April, 1965 report of the Committee on Control of Infectious Disease, American Academy of Pediatrics.

Experience in Michigan

A similar measles education campaign was conducted in Michigan last year. It was accompanied by a five-fold increase in measles immunization rate during the campaign. OSMA officials feel it is a public service obligation of the Association, and its component county societies, to promote this new preventive tool rather than leave the job to a lay or political organization.

Dosage schedules for measles vaccine, as recommended by the Public Health Service Advisory Committee on Immunization Practice (Morbidity and Mortality Weekly Reports 14:64 February 20, 1965), are summarized in the table accompanying this article. It is to be noted that three types of vaccines are available:

Three Types of Vaccines

(1) Inactivated vaccine, (2) live attenuated vaccine (Edmonston strain), and (3) live "further attenuated vaccine." The live vaccines produce immunity for longer periods of time than do the inactivated vaccine, and do it with but one dose. The live vaccines have the disadvantages, however, that they produce a febrile reaction in 10 to 30 per cent of the inoculated children, from the sixth to the tenth day. The "further attenuated vaccine" (Schwartz strain) produces reactions less frequently than the Edmonston strain. Reactions can be reduced by simultaneous administration of Measles Immune Globulin or prior inoculations with inactivated vaccine.

Live virus vaccine should not be administered to infants less than twelve months of age because they may retain maternal antibody which may interfere with antibody response. Schedule 5, as shown in the table, should be a good program for routine immunization of infants under one year of age. Schedules 2 and 3 are the most generally employed for children over twelve months because they provide the most prolonged protection for the least number of injections. Children in the preschool age are particularly prone to develop complications of measles, so immunizations as soon after nine months of age as possible is to be urged.

(See table on facing page.)

Immunization is particularly recommended for children in high risk groups such as those with heart disease, cystic fibrosis, tuberculosis, asthma and other chronic pulmonary disease. Attention is directed to the fact that inactivated vaccine should be used for children with altered immune response such as that resulting from lukemia, steroid therapy, irradiation, alkylating agents, and antimetabolities.

A child afflicted with measles encephalitis may be as crippled as one afflicted with paralytic poliomyelitis. In 1961, nearly five times more children were killed by measles than by poliomyelitis. The Ohio State Medical Association urges all physicians to take whatever steps are necessary to see that all susceptible children receive measles vaccine.

"Mortus a Morbilli."

Dosage Schedules for Measles Vaccines

Schedule	Type of Vaccine	Age	Doses* and Administration	Comment
1	Live, Attenuated Vaccine (Edmonston Strain)	12 months and older	1	Although the live, attenuated vaccine may be administered safely with or without the simultaneous administration of Measles Immune Globulin, most physicians will wish to use the two combined because of the lessened frequency of clinical reactions.
2	Live, Attenuated Vaccine plus Measles Immune Globulin	12 months and older	1 plus Measles Immune Globulin (.01 cc per pound at different site with different syringe)	The live attenuated vaccines should be administered only to those 12 months of age or older since residual maternal antibody may interfere with a satisfactory response among younger children.
3	Live, "Further Attenuated Vaccine" (Schwartz strain)	12 months and older	1	Clinical reactions following the "Further Attenuated Vaccine" are relatively infrequent: Measles Immune Globulin is not necessary with this Vaccine.
4	Inactivated Vaccine	Any Age	3** (monthly intervals) plus a booster dose after one year	In view of the rapid fall-off in antibody and evidence of decreasing immunity following a primary immunization series, use of this vaccine is not preferred except for special groups in which live attenuated vaccine is contraindicated. The degree and duration of protection which might be afforded to those given a booster has not yet been determined.
5	Inactivated Vaccine followed by Live, Attenuated Vaccine	12 months and older	1 dose inactivated vaccine followed in 1 to 3 months by 1 dose live attenuated vaccine	The preceding administration of inactivated vaccine serves to reduce the frequency and severity of clinical reactions following live attenuated vaccine administration.
		Under 12 months	3 doses inactivated vaccine at monthly intervals followed by 1 dose live attenuated vaccine at 12 months of age or older	The live attenuated vaccine should be administered only to those 12 months of age or older since residual maternal antibody may interfere with a satisfactory response among younger children.

*Manufacturers' directions regarding volume of dose should be followed.
**In view of rapidly declining antibody levels and protection, at least one booster dose about a year later is necessary. Data are not yet available to indicate when or with what frequency additional booster doses might be required.

Spring Pediatrics Course Offered by Ohio State

The faculty of the Department of Pediatrics, College of Medicine, Ohio State University and the staff of The Columbus Children's Hospital will sponsor a postgraduate course for pediatricians on March 30, 31 and April 1, 1966. The program will include formal presentations, small discussion groups and demonstration of cases illustrating recent advances in pediatrics.

Attendance of the course is limited to 75. The registration fee is $60.00. For program details write: Center for Continuing Medical Education, Ohio State University, 1645 Neil Avenue, Columbus, Ohio 43210.

Professional Placement Service For Nurses Is Maintained

Physicians are reminded that the Ohio State Nurses Association maintains the Professional Counseling and Placement Service as a function of the organization. The service compiles records of nurses, refers positions to them and sends professional biographies to prospective employers.

Additional information may be obtained from Mrs. Madlyn Lee Schmidt, R. N., Assistant Executive Director, The Ohio State Nurses Association, 4000 E. Main Street, Columbus, Ohio 43213.

Dr. Jane P. McCollough, Cleveland, was elected president of the Ohio Thoracic Society at a recent meeting in Granville.

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WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

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Regular Medical Expense Insurance On Increase, Institute Reports

Over 108 million Americans have regular medical expense insurance which helps pay nonsurgical doctor bills, the Health Insurance Institute reported.

The coverage is provided in many basic hospital, major medical and other health insurance policies.

This type of protection has grown from 47,248,000 persons insured at the end of 1954 to 108,717,000 persons insured at the end of 1964, according to the Institute.

The growth of this coverage is one measure of how the American people have materially broadened their health insurance protection over the past ten years, the Institute said.

At the end of 1954, more than 101 million Americans had hospital expense coverage, indicating that nearly five out of every ten persons with hospital insurance also had regular medical.

Ten years later, more than 151 million persons had hospital insurance, so that seven out of every ten persons with hospital insurance now have regular medical protection, said the Institute.

Regular medical expense protection can be expected to continue to grow, the Institute said. It estimated that as of June 1, 1965 some 111 million persons had this coverage.

Benefits paid by insurance companies to persons covered by this insurance have increased three times as fast over the last 5 years as the climb in the number of persons protected, the Institute said.

From the end of 1959 to the end of 1964 the net insurance company average of persons with regular medical expense insurance climbed from 38.2 to 55.2 million, a 43.3 per cent increase.

At the same time, the total amount of benefits paid by insurance companies for these physician expenses, including benefits for such expenses received under major medical expense policies, increased 132 per cent, from $236 million to $548 million.

Ohio Among Top States in Number Of Health Insurance Groups

After Texas, other states leading in the number of licensed health insuring organizations include Illinois with 461, California and New York 416 each, Florida 414, Pennsylvania 413, Ohio 382, Indiana 377, Georgia 360, and Washington 351.

Ohio has 343 insurance companies, 10 Blue Cross, Blue Shield and medical society plans, and 29 independent plans, according to the Health Insurance Institute.

The Third Annual Midwest Conference on Anesthesiology will be held at the Continental Plaza Hotel, Chicago, April 28-30, 1966. Details may be obtained by writing T. L. Ashcraft, M. D., general chairman, 33 East Cedar Street, Chicago, Illinois 60611.

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

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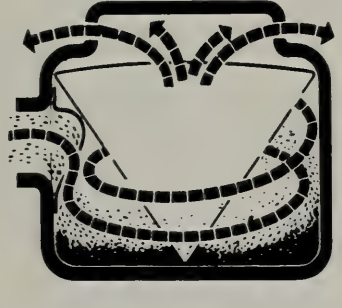
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has the scientific cleaning features that hospitals need most

All "vacuum" cleaners were much the same until the FILTER QUEEN SANITATION SYSTEM was designed. FILTER QUEEN'S patented Sanitary Filter Cone eliminates the need for messy bags, traps practically all airborne contaminants passing into the machine (Harvard Medical School Report in Journal of the American Medical Association, November 25, 1958).*

Experienced hospital housekeepers know this well. That is why FILTER QUEENS have replaced every type of vacuum cleaner in hundreds of hospitals throughout the world.

FILTER QUEEN has no porous bag that permits dust and dirt to reenter the room. FILTER QUEEN operates on an entirely different principle, "Cyclonic Cleaning Action." Here's how it works: Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the



container; then is whirled by centrifugal force away from the cone. Dust and dirt are dropped to the bottom of the container. (See illustration.) Air, being lighter, is funnelled to the center of the "cyclone," filters through the Sanitary Filter Cone and returns to the room dust-free.

Why not ask your local FILTER QUEEN Distributor to make the dramatic handkerchief test (pictured at left) in your hospital? There is no better way to prove the improvement in cleaning ability between a FILTER QUEEN SANITATION SYSTEM and any type of vacuum cleaner. (You'll find your distributor listed in the Yellow Pages; or write Health-Mor, Inc. direct).

**We will be glad to send you a reprint of this report on request.*

What hospital administrators say about FILTER QUEEN

"I heartily recommend to any hospital administrator who is presently unhappy with the type of cleaning machine in use, that he try FILTER QUEEN for only two days and the machine will sell itself."

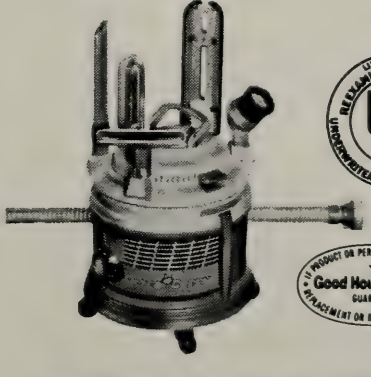
"The FILTER QUEEN is great—a very important factor in patient areas, and is constructed so as to prevent air turbulence of dust at floor level. Filtering of the air, while in general operation, is also a very important and desirable factor."

"One of the most pleasing features of the machine is its quietness. We can even clean in the rooms while occupied by the patients, and many have commented on how pleasant it is not to be disturbed by noisy, old-fashioned vacuum cleaners anymore."

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"We thought we had a clean hospital and a fairly good method of achieving acceptable sanitation, but this little machine made us revise our thinking and our methods."

"A quiet motor which possesses excellent cleaning power and the convenience of having to clean out the cleaning compartment only once a month, has proved very advantageous. One of the most important points . . . is that there is no bag to empty."



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Two Ohio Physicians Join Project Viet-Nam



Two Ohio physicians are in this group of volunteers for Project Viet-Nam, poised in Los Angeles on December 2 before their flight to Saigon. Standing, extreme left, is Dr. Aaron I. Grollman, Cincinnati, and seated second from right is Dr. John E. Stephens, Columbus.

10 Doctors Leave for Viet-Nam To Serve Two-Months Tours

Dr. Edwin W. Brown, Jr. (seated far left in the picture), associate medical director of Project HOPE and project director of Project Viet-Nam, points out locations of assignments on a map to the latest group of American doctors to volunteer two-months' service in South Viet-Nam.

The doctors (left to right, seated) Dr. Brown; Dr. Isaiah Reed Salladay of Pierre, S. D.; Dr. S. William Kalb, Newalk, N. J.; Dr. Wayne G. Parker, Oberlin, Kans.; Dr. John E. Stephens, Columbus, Ohio; Dr. Julius D. Krombach, Henderson, N. Y.;

(Standing) Dr. Aaron I. Grollman, Cincinnati, Ohio; Dr. Warren B. Ross, Nampa, Idaho; Dr. James S. Vanderhoof, Ross, Calif.; Dr. J. Ralph Dunn, Tarboro, N. C.; and Dr. Charles A. Rodman, Minot, N. D.

The 10 doctors were briefed by Dr. Brown in Los Angeles on December 2 and flew to Saigon the next day.

Additional information may be obtained by writing Project Viet-Nam, 2233 Wisconsin Avenue, N. W., Washington, D. C., 20007.

Two Ohioans Scheduled to Participate In Washington Diabetes Program

Two Ohio physicians are on the program for the 13th postgraduate course offered by the American Diabetes Association at the Mayflower Hotel in Washington, D. C., on January 19-21.

Dr. George J. Hamwi, professor of medicine and director of the Division of Endocrinology and Metabolism, Ohio State University College of Medicine, will discuss the current status of oral agents, and participate in other phases of the program.

Dr. Max Miller, associate professor of medicine and director of the Clinical Research Center at Western Reserve University School of Medicine, will speak on the topic of pregnancy and diabetes and will take part in a panel discussion.

Additional information about the program may be obtained from the association at 18 East 48th Street, New York, N. Y. 10017.

Dr. Bertha A. Bouroncle, associate professor of medicine in the Ohio State University College of Medicine, has been awarded a $31,766 grant from the U.S. Public Health Service to support her investigation of tissue culture of human bone marrow.

OSMJ Scientific Section

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The Application of Genetics In Medicine Today

RICHARD M. GOODMAN, M.D.

DURING the past decade, the contributions of basic genetics to medicine has done more to reshape the future of medicine than any other scientific discipline. This new found specialization of medical genetics has grown with unbelievable rapidity. Though much of the work in medical genetics, along with its advances, are centered in an academic environment, the physician of today must be aware of the practical applications that have evolved.

The purpose of this paper is to relate some of the advances in medical genetics that pertain to the daily practice of medicine. Before discussing the various aspects of application, it is imperative that one be acquainted with a few general genetic terms and concepts.

The field of medical genetics can be divided into four subdivisions: (1) clinical genetics which mainly is concerned with family studies, (2) biochemical genetics, (3) cytogenetics which deals primarily with the study of chromosomes and other genetic markers in cells and (4) population genetics. This paper will touch upon all of these areas with the exception of population genetics.

Terms and Concepts

In 1956, the observation was made that the nucleus of human somatic cells contains 23 pairs of chromosomes (a total of 46) instead of the previously accepted number of 48 chromosomes. Of the 23 pairs of chromosomes, 22 are referred to as *autosomes* and the remaining pair is called the *sex chromosomes,* XX in the female and XY in the male.

Chromosomes are rod-like structures within the nucleus of a cell, containing hundreds of genes arranged in a linear order. These *genes,* as the chromosomes themselves, are made up of a chemical substance called desoxyribonucleic acid, *DNA,* and are the functional units of the chromosomes. Genes function as blueprints for the manufacture of proteins. The factories which produce the various protein molecules are located outside the cell nucleus in cytoplasmic structures called *ribosomes.* The main component of the ribosome is a form of ribonucleic acid *(RNA).* The blueprints for the manufacture of the numerous proteins in the body are transported from the genes in the nucleus to the ribosomes in the cytoplasm via a special form of RNA referred to as "messenger" RNA. The building blocks, or the various amino acids that go to make up the protein molecules, are contained in the cytoplasm. Each amino acid is activated by a specific enzyme and then carried to the ribosome for synthesis of a given protein. The transport of the amino acids to the ribosome is per-

The Author

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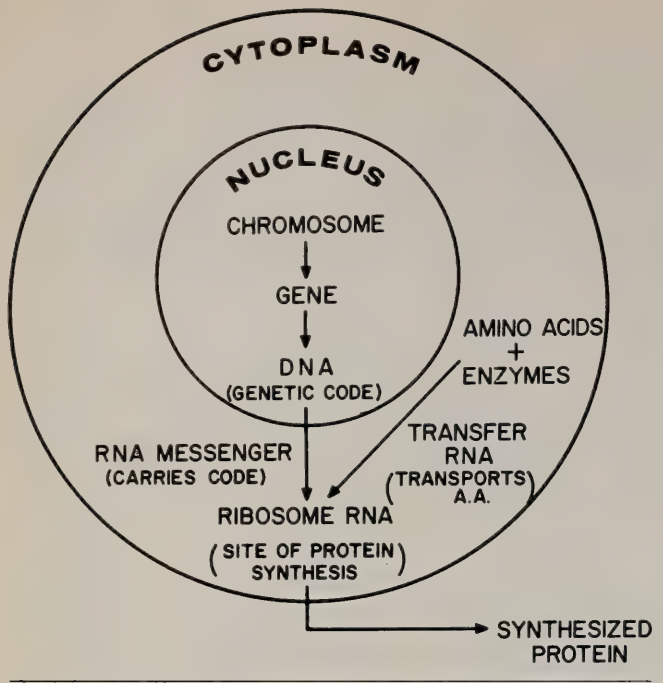


FIG. 1. *A brief schematic diagram showing the proposed mechanism of protein synthesis.*

formed by another form of RNA referred to as "transfer" RNA (Fig. 1).

In most instances, an individual receives a *haploid number* (half the basic chromosome complement or one of each pair) of chromosomes from each parent, thus resulting in a full *diploid* complement of chromosomes. The reductional division of germinal cells producing a haploid number of chromosomes is referred to as *meiosis;* while the somatic division of cells is called *mitosis.* The cell resulting from the fertilization of an egg by a sperm restoring the diploid number of chromosomes is called a *zygote.* In various abnormal chromosomal states, an irregular number of chromosomes *(aneuploidy)* is found, that is 45, 47, 48 and so on. This occurs as a result of loss or addition of one or more chromosomes, be they autosomes or sex chromosomes.

Mutant genes (altered genes) are carried on either the autosomes or the sex chromosomes. In general, the *Y sex chromosome* of man probably carries little genetic material other than that which determines maleness; while the *X chromosome* of a female is known to carry many genes other than those determining sex. The term *X-linked* therefore refers to those genes carried only on the X chromosome. For the sake of simplicity and understanding, genetic traits or diseases are generally said to be inherited as either dominant or recessive — that is, autosomal or X-linked dominant or recessive.

A dominant trait may be inherited in either the *homozygous* (DD) or *heterozygous* (Dd) state, though most are thought to be of the latter form. Other features of the inheritance of a dominant trait are that one of the parents, one half of the sibs and one half of the offspring would be expected to show the condition in any given pedigree. Generally, there is vertical transmission from generation to generation. The chance of recurrence is 50 per cent in subsequent members of a sibship.

A recessive trait in an individual is generally inherited in the homozygous state (dd). Each parent contributes an identical mutant gene to the affected child who carries a double dose of the gene. Both parents are clinically normal but are genetic carriers. The chance of recurrence in another child (or in a sib) is one in four. *Consanguineous marriages* (between relatives) are important to note in connection with recessive conditions. Closely related individuals have a greater chance of carrying the same genes, thus children from such matings are more frequently homozygous for various genes than are children from non-related marriages.

In understanding *X-linked* inheritance (sex linked in the old terminology), it is important to recall that the mother receives an X chromosome from each of her parents and gives either one or the other to her sons and daughters. A daughter receives one X from the mother and in addition a second X chromosome from the father. Thus, in an X-linked recessive disease such as classical hemophilia the mother, although clinically normal, is a carrier. She gives the disease to one half of her sons while one half of her daughters are carriers. The daughters in turn will give the disease to one half of their sons.

Genetic Diseases

With these brief concepts in mind, let us begin to look at some of the various genetic disorders. Genetic diseases can be divided into three categories: (1) those associated with a known chromosomal abnormality, either of the autosomes or sex chromosomes, (2) those which are due to a mutant gene producing a known alteration in a protein or enzyme — diseases in the latter group are referred to as belonging to the *inborn errors of metabolism,* and (3) those that make up the largest group in which the basic abnormality has not been defined.

Chromosomal Abnormalities

The Autosomal Trisomy Syndromes

Physicians practicing obstetrics and pediatrics should be aware of this important group of disease states. Infants in this group usually have gross clinical findings due to an extra autosome which can be demonstrated readily by chromosomal analysis. In 1959, it was shown that individuals with *mongoloid idiocy* (now referred to as Down's syndrome by many) had an extra autosome associated with chromosome number 21. More recently, chromosomal defects other than 21 trisomy have been noted in patients with Down's syndrome. The following paper by Dr. Eber will discuss the various chromosomal changes that have been observed in this genetic disease. Mongolism is a common condition since it occurs in approximately 1 in 600 births of the general population.

The *13–15 syndrome* or D trisomy syndrome is

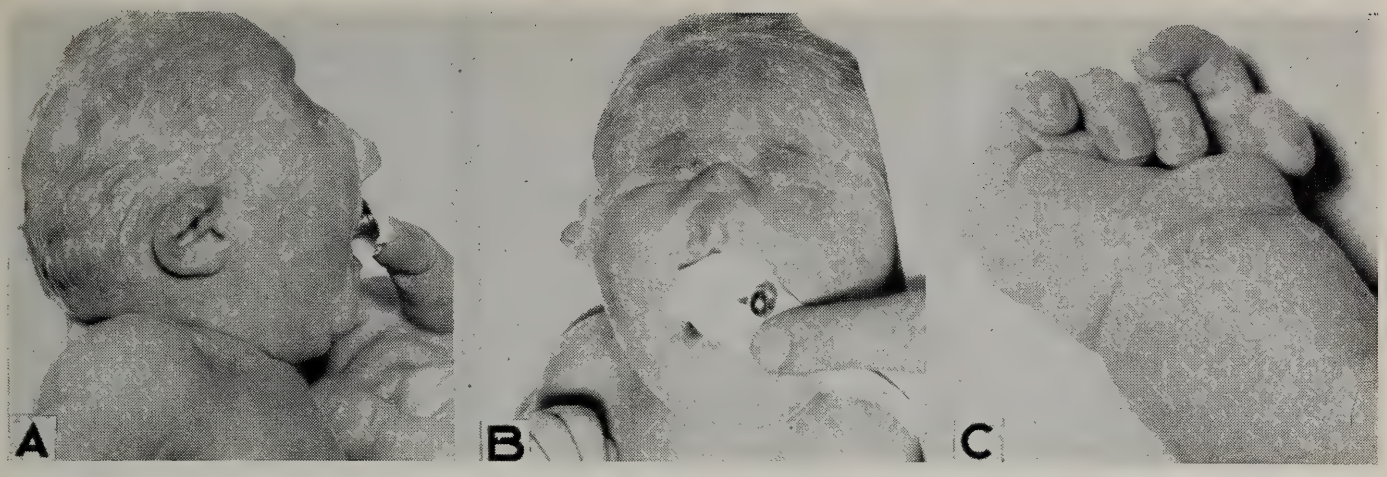


FIG. 2. *A female infant with the 13–15 trisomy. At the time of birth, the mother was 39 and the father was 40 years old. The following anomalies can be noted,* (A *and* B) *microcephaly, low set and malformed ears, single external nasal orifice, anopthalmia* (C) *polydactyly and clenched fingers. In addition, the patient had many internal congenital defects.*

characterized by an extra chromosome in the 13–15 group. These infants frequently have many or all of the following defects: deafness, seizures, retroflexibility of the thumbs, polydactyly, cleft palate, harelip, hemangioma, and eye defects, notably anophthalmia or micropthalmia (Fig. 2).

Infants with the 18 or E trisomy syndrome (Fig. 3) frequently show spasticity, clenched fingers, overlapping index fingers, micrognathia, malformed ears, umbilical or inguinal hernias, ventricular septal defect, patent ductus, Meckel's diverticulum, and ectopic pancreatic tissue.

Common to both the 13–15 and 18 trisomy syndromes are mental retardation, low-set ears, rocker bottom feet, anomalies of the heart, increased age of the mother at time of conception, and failure of the infant to thrive. The incidence of these syndromes is not known though they are thought to occur much less frequently than Down's syndrome.

Other Autosomal Abnormalities

Within the past year, Dr. Lejeune of the University of Paris (the man who first observed the chromosomal defect in Down's syndrome) has described a new syndrome called the *Cat Cry* or *cri du chat* syndrome. Infants with this disorder have a cry that sounds like a cat in pain and their chromosomal defect is a loss of a chromosomal fragment from the short arm of chromosome number 5. These infants



FIG. 3. *The karyotype of a female infant (XX) with the trisomy 18 syndrome.*

have many of the abnormalities noted in the previous trisomy syndromes such as mental retardation, low-set ears, small mandible, and congenital defects of the heart. In addition, they may have the simian crease noted in patients with Down's syndrome and downward slanting eyes set far apart.

In the previous syndromes which have been discussed, the gross abnormalities that accompany them are thought to be the result of the genetic alteration in the amount of chromosomal material present. In other words, a causal relationship seems apparent.

When one discusses the chromosomal changes that have been observed in various neoplastic and other diseases, such a causal relationship remains less apparent. Nevertheless, there are two diseases in which chromosomal changes seem to be consistent. The first and most important is that of chronic myelocytic leukemia (CML). In 1960, two research workers in Philadelphia demonstrated that patients with CML have a small number 21 chromosome, while the other 21 chromosome is normal in size. This small chromosome has come to be called the Ph^1 or Philadelphia chromosome and is observed characteristically only in patients with CML. More recently, in patients with Waldenström's macroglobulinaemia, a very large chromosome has been noted in addition to the normal-appearing 46 chromosomes. This is mentioned only to point out that in a variety of neoplastic, viral and diseases of unknown etiology, such as Waldenström's macroglobulinaemia, various chromosomal abnormalities have been demonstrated. Yet, to date, only the Ph^1 chromosome has proven to be consistent and thus diagnostic for a given neoplastic disease. Further chromosomal research work will undoubtedly prove useful in characterizing other previously mentioned diseases.

Sex Chromosome Abnormalities

One cannot discuss this group of disorders without the knowledge of what promoted its investigation. In 1949, it was recognized that the cell nuclei from normal female tissue contained a small body called *sex chromatin* (or Barr body). This Barr body was observed to be adjacent to the nuclear membrane and stained specifically for DNA. Cells which contain such a structure are termed chromatin-positive. Normal male cell nuclei do not contain a sex chromatin body and are termed chromatin-negative. It is thought that the sex chromatin represents part or all of one X chromosome which may be genetically inactive. The method (buccal smear) for analyzing cells for the presence of a sex chromatin body is relatively simple and can be considered an office procedure.

Using the buccal smear test as a screening technique, a considerable number of abnormalities have been recognized in which there is an altered number of sex chromosomes. The patient is sterile in nearly all of these cases. It therefore behooves the physician seeing patients for a sterility problem to be aware of these syndromes. The Klinefelter syndrome (XXY) and the Turner syndrome (XO) are the most common sex chromosome abnormalities.

In the *Klinefelter syndrome,* chromatin-positive males are characterized by primary hypogonadism invariably associated with small testes and variable clinical features including eunuchoidism and gynecomastia (Fig. 4). They frequently seek medical

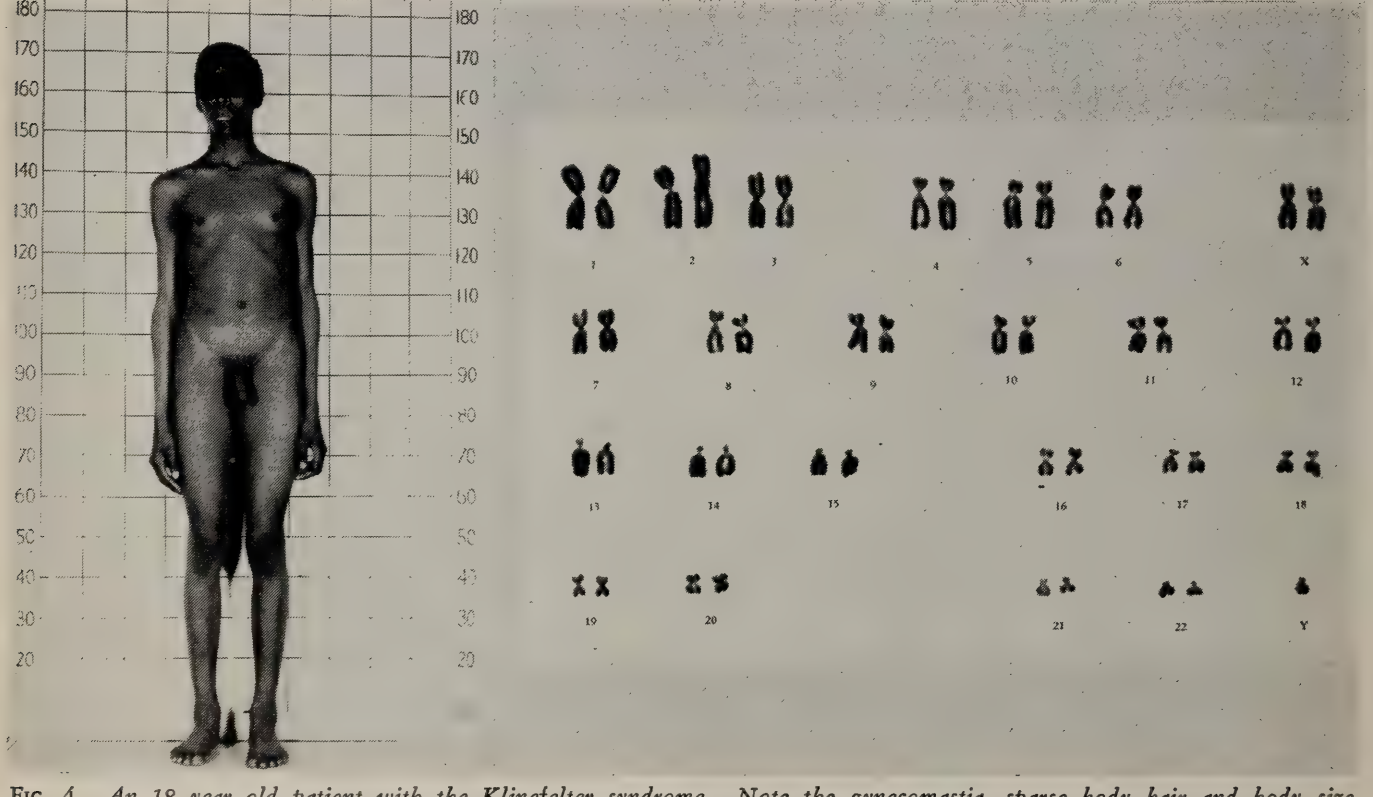


FIG. 4. *An 18 year old patient with the Klinefelter syndrome. Note the gynecomastia, sparse body hair and body size. He never shaved and also demonstrated small testes. His chromosome pattern shows the (XXY) abnormality.*
(From McKusick, V. A.: *Medical Genetics 1958-1960,* St. Louis: C. V. Mosby, 1961, p. 172.

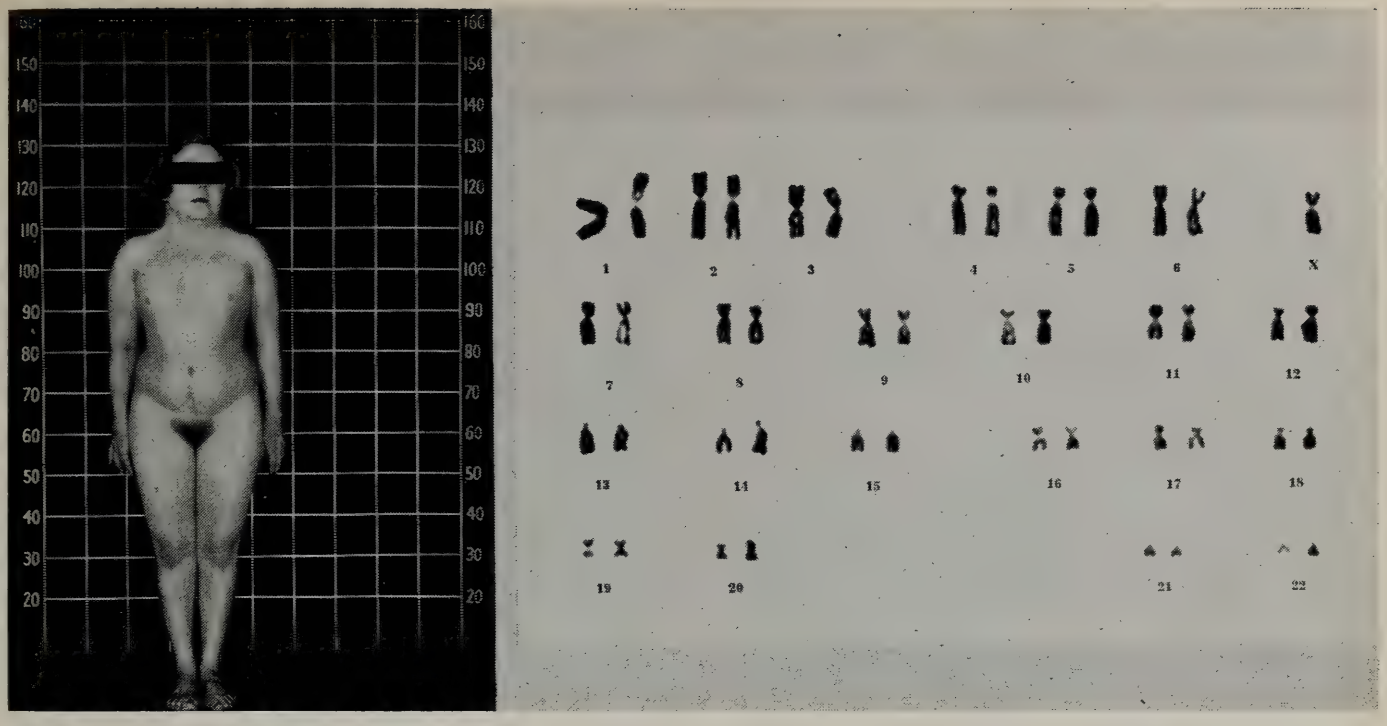


FIG. 5. *A 37 year old patient with the Turner syndrome. Note the short stature, web neck, shield-like chest and wide set nipples. She has been operated on for coarctation of the aorta. Her chromosome pattern (XO) shows the absence of a (X) sex chromosome.*

(From McKusick, V. A.: *Medical Genetics 1958-1960,* St. Louis: C. V. Mosby, 1961, p. 174.

attention because of problems of infertility, eunuchoidism, or gynecomastia. Others may have no complaints, and the only incidental finding is small testes. The Klinefelter syndrome has been estimated to occur about once in every 400 male births.

The *Turner syndrome* (or gonadal aplasia) refers to chromatin-negative females who fail to mature at puberty and maintain infantile internal and external genitalia throughout adult life. Pubic and axillary hair develops but the breasts remain prepubertal. Amenorrhea is often the presenting complaint. Clinically, these patients are of short stature and frequently have webbing of the neck, a shieldlike chest, coarctation of the aorta, hypoplasia of the nails, short fingers, abnormal facies with micrognathia, and pigmented moles (Fig. 5). Histologically, there is absence of a true gonad and, in place of the ovary, there is a streak of white tissue composed of ovarian stroma lacking germinal follicles. The frequency of this syndrome in the general population is not known. One authority suggests a minimum frequency of one in 5,000 female births but others are of the opinion that it is probably higher.

These chromosomal aberrations are produced by abnormal chromosome divisions in the germinal cells before or shortly after fertilization, resulting in an altered number of sex chromosomes.

Biochemical Abnormalities

Thoughts of diseases producing metabolic blocks due to mutant genes were initiated and set forth by Sir Archibald Garrod in his famous lectures entitled, "Inborn Errors of Metabolism." Advances made in this area of study have been not only phenomenal in number but in many instances, of utmost importance to patients affected with a given disorder. In several of the "inborn errors," early recognition is essential for the patient's future well-being. The following disorders or traits are partially understood and can be treated either supportively or totally.

Sickle Cell Disease

Of all the diseases known to man, few have been studied as intensely and with such reward as sickle cell disease. The electrophoretic identification of the abnormal hemoglobin marked the early probing of the basic structure of the hemoglobin molecule. Further studies have beautifully delineated the basic defect as due to the substitution of a valine residue for a single glutamic acid residue in the beta chain of hemoglobin. Other hemoglobinopathies have been shown subsequently to be due to an abnormal amino acid substitution.

G6PD Deficiency

The development of hemolytic anemia in the Negro, in people of Mediterranean extraction, and in the Sephardic Jew is often on the basis of a metabolic defect in the erythrocyte — a deficiency of the enzyme, glucose 6-phosphate dehydrogenase (G6PD). The expression of this abnormality is triggered by the ingestion of various drugs and foods, such as primaquine, nitrofurantoin, fava beans, and other agents. The diagnosis of G6PD deficiency, which is an X-linked disease, can easily be confirmed by various laboratory techniques. Patients with this disorder do well if the initiating agent is discon-

tinued and if subsequently it and all other products capable of producing the disease are avoided.

Pseudocholinesterase Deficiency

When anesthesia is contemplated, it is well to know that some patients lack the enzyme pseudocholinesterase in their blood and thus are slow to destroy the muscle relaxing drug, succinylcholine. This condition is called hereditary pseudocholinesterase deficiency. The enzyme deficiency alone is harmless, as is the conventional dose of the drug, but, when succinylcholine is given to a genetically susceptible individual, prolonged apnea occurs.

INH Inactivation

In the treatment of tuberculosis with *isonicotinic acid hydrazide* (INH), it has been shown that the rate of inactivation of the drug is genetically controlled. Some individuals are rapid activators, while others inactivate the drug slowly. Therapeutically, the rapid inactivator receives less benefit from the same dose of drug as compared to the slow inactivator.

Phenylketonuria

Mental retardation resulting from phenylketonuria (missing enzyme–phenylalanine hydroxylase) if recognized early enough can, in many instances, be prevented by eliminating the amino acid, phenylalanine, from the infant's diet. Figure 6 illustrates the site of the metabolic block in phenylketonuria and also two other genetically determined diseases (albinism and alkaptonuria) of altered aromatic amino acid metabolism. These are only a few of the biochemical defects in which recognition is advantageous to the affected individual. Certainly, there are many more conditions to be uncovered.

In referring to the subject of biochemical genetics, one should be aware that besides diseases in which a missing enyzme has been identified (for example, G6PD deficiency, pseudocholinesterase deficiency, and phenylketonuria), there are other disorders in which the primary defect is not enzymatic but is due to an alteration or lack of a known protein. The hemoglobinopathies and the hereditary clotting disorders are cardinal examples of this latter group.

There is also a larger group in which the general metabolic area involved is suspected but, as yet, the precise defect has not been pinpointed. Some common diseases in this group include cystic fibrosis of the pancreas, the porphyrias, gout, osteogenesis imperfecta, and Marfan's syndrome.

Other Genetic Disorders

In many conditions, the role of genetic factors is probably significant but remains to be defined precisely. Atherosclerosis, hypertension, allergies, rheumatic diseases, and various neoplastic diseases are a few of the disorders with hazy genetic implications.

Approach to a Possible Genetic Problem

The recognition of a genetic disease may often be difficult, especially if the clinical and laboratory findings are not suggestive of a known disorder. A thorough family history is always important. Inquiry as to parental consanguinity is helpful in the evaluation of possible recessive inheritance. So often this point is omitted in case reports of a genetically determined disease. There is no substitution for keen observation both in the physical examination and history. Unquestionably, new genetic disorders await recognition by the astute observer.

Once a disorder is suspected, other family members must be evaluated as to their genetic make-up — that is, whether they are affected, normal, or carriers who appear normal. Ultimately, the physician must turn to the laboratory in trying to delineate the basic defect. Many elaborate techniques are now available to help make this delineation.

Once a physician recognizes a genetic disorder, he will face a multitude of questions, some of which cannot be answered at this stage of knowledge. What is the cause of the disease? What can be done? Will the children be affected? What are the chances of

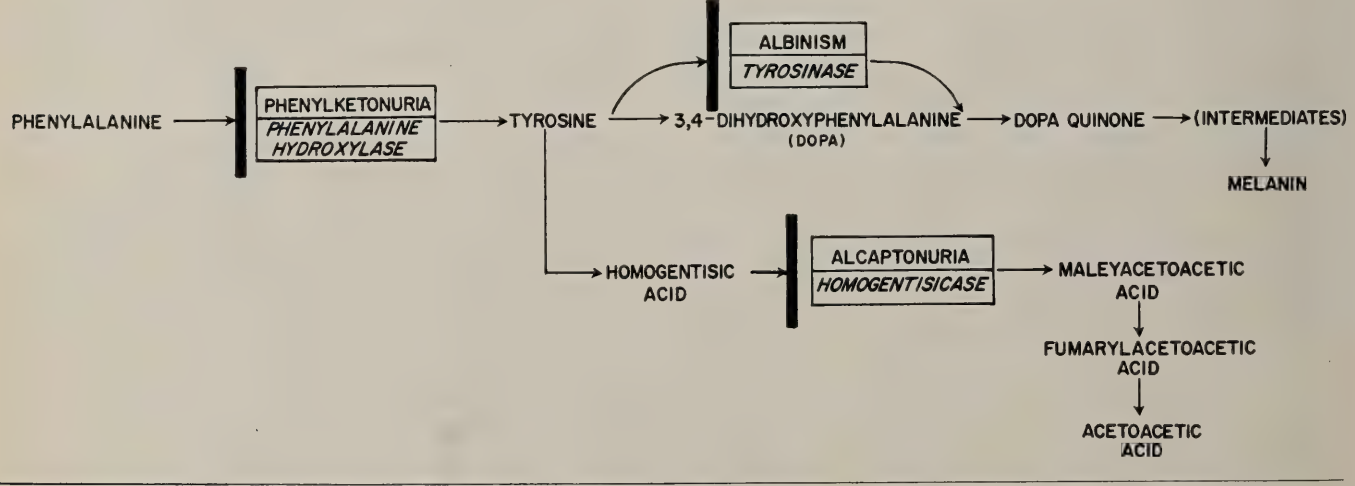


FIG. 6. *Sites of metabolic block in the degradation of phenylalanine producing the disorders of phenylketonuria, albinism and alkaptonuria. The slanted words in the blocks indicate the missing enzyme.*

having a normal child? To answer many of these questions, the physician will need to educate himself.

Summary

The application of genetics in medicine today can be thought of in the following terms:

I. *Diagnosis:* Chromosomal studies are now available in many hospitals and such studies can be of diagnostic value for the physician seeing an infant with multiple congenital anomalies. Chromosomal analysis should also be employed after a buccal smear test, when the results of the latter do not coincide with the appearing sex of the patient in question.

There are numerous biochemical determinations now available to aid in the diagnosis of many genetic disorders of altered protein synthesis.

II. *Counseling:* In many genetic disorders, it is possible to state the genetic risk in rather precise terms. For example, any child of a parent affected with an autosomal dominant disorder has a one in two chance of having the same condition as the affected parent. In an autosomal recessive disorder, once an affected child is born to unaffected parents, the risk to any child subsequently born is one in four. Genetic counseling is now possible for many known conditions and should play a vital role in the overall care of a patient.

III. *Treatment:* Treatment of genetic disorders should not be looked upon as a hopeless situation. True, one cannot cure a patient with genetic disease, but tremendous progress has been made during the past few years with regard to certain conditions. Phenylketonuria and galactosemia are two severely mentally retarding disorders, which can be treated if diagnosed early enough. Proper treatment can prevent the irreversible changes that produce mental retardation.

Other genetic disorders can be aided greatly if one is aware of the condition.

In conclusion, medical genetics can play a practical role in medicine today. This role will continue to increase as our knowledge advances and thus we must equip ourselves not only for the future, but for the present.

Acknowledgment: The author is indebted to Dr. M. A. Ferguson-Smith, of the University of Glasgow, (formerly at Johns Hopkins Hospital) in whose laboratory the chromosome studies were performed and to Mrs. Patricia Roberts for typing the manuscript.

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(A list of texts pertaining to the subject of medical genetics is available upon request.)

SPECIALTY BOARDS. — Members of specialty boards are conscientious, honest, dedicated persons who contribute freely of their time and effort, often at great sacrifice, to advance the standards of their specialty, without thought of personal aggrandizement or recompense for their services. Like members of the faculty of a great university sitting at a defence of a doctoral dissertation, they are imbued with a sense of their responsibility to determine the competence of candidates who appear voluntarily before them for certification as diplomates.

Aside from setting up minimal standards which must be met before candidates can appear for examination before a board, such a board performs no function in the educational programme available for training future diplomates. It is the function of a specialty examining board to determine competence only and to certify those who possess it to a sufficient degree to warrant approbation. Somewhat like the dissociation between the judicial and the legislative branches of a modern democracy, a specialty examining board scrupulously avoids participation in that phase of the educational programme which aims at development of competency. Similarly, like a judicial body in and of itself, a specialty board has neither the will nor the authority to prevent the practice of any specialty by a licensed physician, regardless of his ability or lack of it. The chief objective of all specialty examining boards is to elevate and to maintain the standards of specialty practice, and the finite manifestation of their efforts toward this objective is the certificate of competence which they issue to all physicians who can meet minimal requirements of licensure and graduate medical education. — Louis A. Buie, Sr., M. D., Rochester, Minnesota: *British Medical Journal,* 1:543-547, February 27, 1965.

The Importance of Chromosome Analysis In Down's Syndrome

A Case Report of a 21/21 Translocation

LESLIE M. EBER, M. D., and RICHARD M. GOODMAN, M. D.

LANGDON-DOWN (1866) generally is credited with the first description of the relatively common syndrome called mongolism or Down's syndrome.[1] The establishment of 46 chromosomes as the normal number in man[2] led to the discovery of a chromosomal alteration in the cells of patients with mongolism.[3] Although this syndrome has long been recognized as a clinical entity, recent cytogenetic techniques now permit a more definitive diagnosis.

Several authors have commented upon the difficulty of making the diagnosis of Down's syndrome on clinical grounds alone.[4,5] Our case illustrates this point and augments the relatively few reported cases of mongolism associated with a translocation type of chromosomal defect. This report reviews chiefly the various chromosomal abnormalities associated with Down's syndrome and stresses the need for studying chromosomes with regard to genetic counseling.

Case Report

This 31 year old white single woman entered the Ohio State University Hospital on August 10, 1964 for evaluation of glycosuria discovered by a diabetic grandmother. The patient had no other diabetic symptoms. She was the first born of 11 children, when her mother was 19 and her father, 24 years old. The patient's mother stated that there was no prenatal exposure to X-irradiation and that the delivery was full term and normal.

Her early development was noted to be very slow and, because of her retardation, she never attended school. The past history was interesting in that she had only the usual childhood diseases, without frequent respiratory infections. Menarche was at age 15, and her periods have remained scanty and irregular. Although the patient had been seen by physicians in the past, the parents were unaware of the cause of her retardation. There was no known history of consanguinity or mental retardation in other family members.

Physical examination showed a short, slightly obese, obviously retarded woman (Fig.1). Vital signs were within normal limits. Her height was 57 inches, weight 129 pounds, arm span 51½ inches, pubis to heel 27 inches and crown to pubis 30 inches. The head was brachycephalic with a normal female hair line. Epicanthal folds were observed about the eyes. Slit lamp examination of the eyes was normal. The palate was high arched, and the tongue horizontally fissured (Fig. 2). There was poor dental development with severe periodontitis. The neck was supple with no thyromegaly. Breast development was normal. The heart and lungs were unremarkable. The abdomen was slightly pendulous, with no palpable organs or masses. Pelvic examination showed normal external genitalia. The joints were not hyperextensible. Incurving of the little finger (clinodactyly) was noted only on the left hand. There was a wide gap between the great and second toes bilaterally (Fig. 3). Neurological examination was within normal limits except for the mental retardation. She was pleasant and amiable but able to answer simple questions only with short phrases.

The following laboratory determinations were within normal limits: hemogram, urinalysis, blood urea nitrogen, creatinine, fasting and two hour post standard glucose meal blood sugars, cholesterol, serology, protein-bound iodine, achilles tendon test, twenty-four hour I^{131} uptake, serum calcium, phosphorous, and alkaline phosphatase. A buccal smear was positive. The chest x-ray and an intravenous pyelogram were normal. The radiologist commented upon the small size of the skull for a 31 year old woman and the non-fusion of the lambdoidal suture. Electrocardiogram was normal.

Chromosome analysis was performed on peripheral blood. A total of 36 cells were counted, 32 of which showed a 21/21 translocation with a modal number of 46 (Fig. 4). Chromosomal studies performed on the patient's mother, father, and four youngest siblings were normal. Leukocyte alkaline phosphatase determinations showed only the patient's to be abnormally elevated, 219 units[6] (normal 100-180). Fingerprint patterns of the hands showed a triradius near the center bilaterally and a small digital loop in the hallucal area of both feet. Though the commonly observed simian crease of the hand was absent, these other dermatoglyphic findings are seen frequently in Down's syndrome.

Discussion

The reported frequency of Down's snydrome in the general population varies from author to author, probably due to the large number of patients who die during the first year of life and also to diagnostic errors. It is thought to occur in about 1 in 600 live births and to account for 40 to 50 per cent of the mentally retarded among the newborn and approximately 10 per cent of all the mentally deficient.[7]

Mongolism should be considered a syndrome in

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which no single clinical finding is pathognomonic. Clinical diagnosis is made by a careful search for a cluster of features associated with this condition. Some of the more common of these are: mental retardation, brachycephaly (shortening of the occipitofrontal diameter), and epicanthal folds. The syndrome derives its name from the superficial resem-

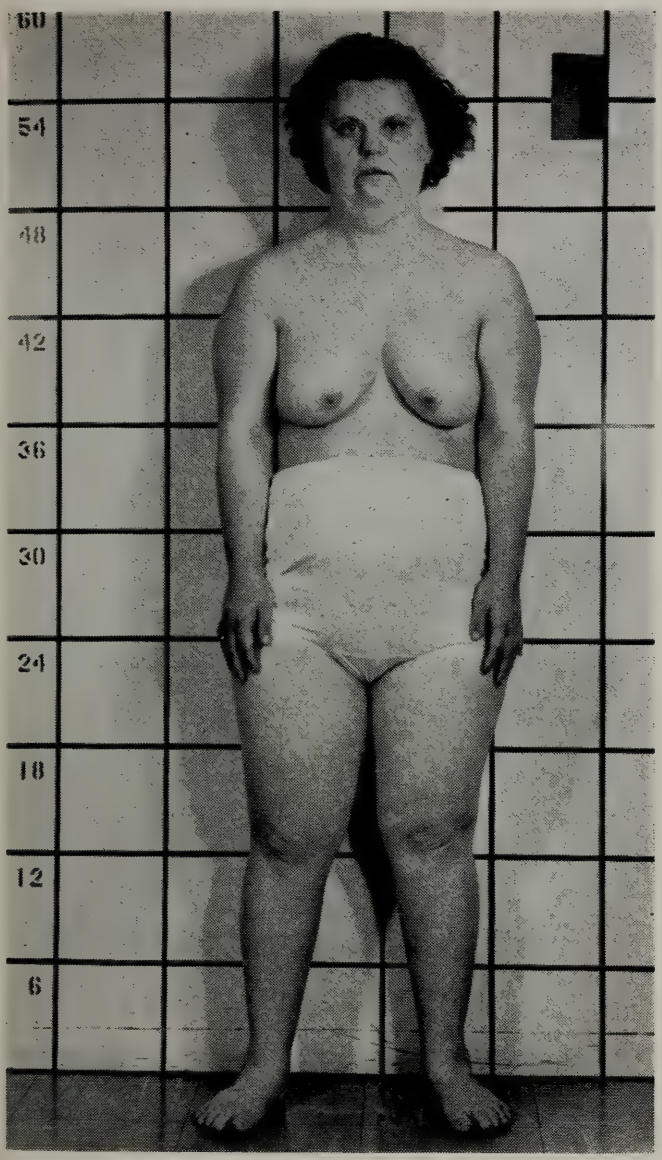


FIG. 1. *Shows the patient to be of short stature and slightly obese. Her facies is suggestive of Down's syndrome.*

blance of the eyes to those of the Mongolian people. Closer examination has shown that Mongolians do not actually manifest epicanthal folds. Part of the diagnostic difficulty in the mentally retarded adult with Down's syndrome stems from the fact that often this fold disappears with advancing age.

As in many forms of mental retardation, convergent strabismus and nystagmus are found frequently. Cataracts appear after age 8 and may be found in about 50 per cent of mongols after age 25. The tongue after the second year may appear "scrotal" with horizontal fissures. The palate frequently may be high with a tendency to clefting and dentition is often poor.

Numerous abnormalities of the extremities have



FIG. 2. *Illustrates the patient's fissured tongue and epicanthal folds about the eyes.*

been described such as malformation of the acetabulum, dwarfism, laxity of the joints, and flabbiness of the muscles. The hand may show the characteristic "simian" line (a transverse fold across the whole palm) and clinodactyly. Finger and toe print analysis often show abnormal patterns.[8] The foot is broader and shorter than normal with the anterior margin forming a horizontal line instead of an arch. About 60 per cent of cases have a large cleft between the big and second toes.

Congenital heart disease is present in up to 60 per cent of cases. A recent series[9] found 40 per cent with congenital heart disease. The leading defects were atrioventricularis communis and ventricular septal defects. Patent ductus arteriosus, atrial septal defects, and isolated aberrant subclavian artery were less common.

Patients afflicted with this syndrome have a marked

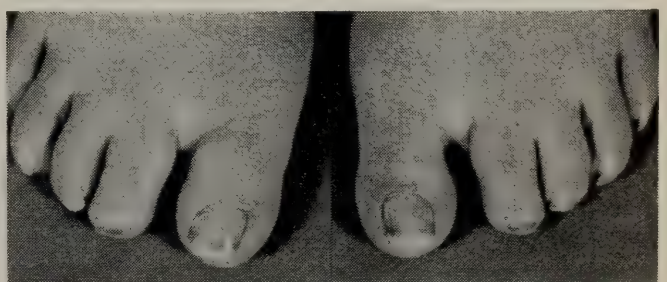


FIG. 3. *Shows the space between the first and second toes which is a frequent finding in Down's syndrome.*

propensity to infections usually of the respiratory tract. In addition, acute lymphatic leukemia is more common in this disorder than in the general population.

Chromosomal aberrations are not unique to this syndrome. They have been observed for many years in rapidly regenerating tissue, cancer cells, and X-irradiated cells of fruit flies. The association of Down's syndrome with chromosomal abnormalities was recognized in 1959.[3] Since then various characteristic karyotypes have emerged.

(A) *Trisomy 21.* This is by far the most common type and the one associated with increasing maternal age. These individuals have cells which contain 47 chromosomes, three of which are number 21 instead of the normal two. This is thought to arise during the meiotic division of gametogenesis by a process referred to as nondisjunction, a failure of the two chromosomes 21 to separate. Thus, the single egg formed can possess either 24 chromosomes (two 21 chromosomes) or 22 (no 21 chromosomes). When the former is fertilized by a normal sperm containing 23 chromosomes, the offspring is a mongol with three chromosomes 21 and a modal number of 47. Such nondisjunction may also occur in the male parent's gametes. In this type of monogolism, family karyotyping has failed to uncover any consistent abnormalities. The probability of a second trisomy 21 child being born to a family in which there is already one trisomy mongol is greater than that which would be expected in a family with one normal child. Furthermore, there is evidence to suggest that the presence of one nondisjunction mongol in a family makes it more likely for the appearance of other types of chromosomal abnormalities to occur and vice versa.[10] It is also conceivable that there is a genetic predisposition to nondisjunction.[11]

(B) *Translocation 15/21.* As in trisomy 21, this chromosomal abnormality has the extra 21 chromosomal material, but the karyotype shows the normal number of chromosomes, 46. Chromosomes are known to break and recombine with the same or different chromosomes during meiosis. When part of one chromosome combines with another, translocation is said to have taken place. If this were to occur in a grandparent's germ cells, it could be transmitted to a parent who phenotypically is normal, but who has only 45 chromosomes. Theoretically, one fourth of the next generation will be nonviable due to a paucity of chromosomal material, one fourth will have Down's syndrome, one fourth will be translocation "carriers" like the parent, and one fourth will be genotypically and phenotypically normal. The above is probably only an approximation, as there are multiple, unpredictable factors involved. Male "carriers" usually produce either mongols or normals and are thought rarely to give rise to other "carriers."[12] Thus, the "carrier" parent can be detected by cytogenetic studies and should be sought for in all cases of translocation monogolism, for there is high risk of producing another mongol or perpetuation of the carrier state. If no "carrier" is identified in the parents, theoretically the risk of having another affected child is less.

Family studies of 15/21 translocation mongolism have shown that either the father or the mother may be the "carrier," that large families derived from a "carrier" will contain several mongols, and that here the incidence of Down's syndrome does not parallel parental age.

(C) *Translocation 21/21.* This type of mongolism is illustrated by our case whose karyotype is shown in Figure 4. One chromosome in the 21-22 group is absent, and a new one is present (arrow).

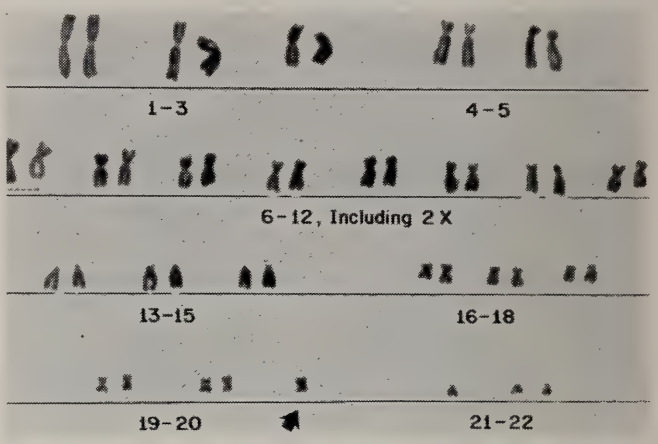


FIG. 4. *Shows the karyotype of the patient. Note there are 46 chromosomes and only one 21 chromosome. The arrow points to the translocated chromosome which is made up of two 21 chromosomes (21/21) attached to each other.*

This represents a translocation between 21/21 or 22/21. This translocation may occur during meiosis in a normal individual and may give rise to a phenotypically normal "carrier" with 45 chromosomes, who in the next generation, may produce a mongol. If one of the parents were a "carrier," there would be a high probability that the next child would also have Down's syndrome. Occasionally, as in our case, no translocation carrier is identified in the parents, making it likely that the translocation occurred probably in one of the parent's *germ cells* and could not be detected in their *somatic cells.*

It should be noted that it is most difficult to distinguish between chromosomes 21 and 22 microscopically. Theoretically, a "carrier" of a true 21/21 translocation would produce only offspring with Down's syndrome. The fact that some "carriers" have produced normal children further lends credence to the difficulty in precisely identifying chromosomes 21 and 22. It is conceivable that these "carrier" individuals are really 22/21 translocations thus accounting for the increased probability of having normal offspring as in 15/21 translocations discussed above.

(D) *Mosaicism.* The cells of this individual show a mixture of trisomy 21 and normal cells.[13] The hypothesis here is that the abnormality arose

after fertilization during one of the early *mitotic* divisions giving rise to two populations of cells.

(E) At least one clinical case of Down's syndrome has been reported in which no abnormal karyotype was demonstrated.[14] This is such a remote finding that it does not preclude cytogenetic studies on all cases of mongolism.

There is no way to distinguish between the various types of mongolism clinically. A careful family history may alert the physician to the possibility of translocation Down's syndrome; however, all cases should be karyotyped. If a translocation is discovered, the parent's cells should also be examined with regard to the carrier state. In this way the physician can advise the family of the possibility of having future children with mongolism. The cytogenetic approach to Down's syndrome also establishes the diagnosis in questionable cases.

The chromosomal anomalies described above are thought of by many as the basic abnormality in Down's syndrome. It is assumed that the extra chromosomal 21 material in some way gives rise to the various characteristics observed in the disorder. It should be pointed out, however, that to date no single mediator between the abnormal chromosome and the patient has been discovered. No consistent enzymatic or hormonal defect has been demonstrated in this disease.

Summary

A case of Down's syndrome in an adult woman with a chromosomal 21/21 translocation has been described. No translocation "carrier" was identified in the family. The various types of chromosomal abnormalities found in mongolism have been discussed with emphasis on the necessity of performing cytogenetic studies for the purpose of genetic counseling.

Acknowledgment: The authors would like to express their thanks to Dr. George Hamwi for his permission to publish this case, to Mrs. Glenna Currier for chromosome and finger print studies, and to Mrs. Pat Roberts for preparation of the manuscript.

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MEDICAL RESEARCH, like women's clothing, is subject to fashion. Molecular biology at present is in style; a generation ago most investigators were microbe hunters. What comes next?

This, I think, can be predicted with fair certainty: molecular biologists will proceed from the study of processes to that of whole organisms and of societies of organisms. The myriad of biochemical events revealed by analysis of living systems must be reassembled, at least conceptually, to bring life back to biology. Functional unity and the purposeful responses of organisms somehow derive from an ensemble of biochemical processes, but how this comes about is quite unknown. We do not even have the beginnings of a theory that can be taken into the biochemical laboratory for experimental test. Yet the question is there, and it is too challenging to be ignored. Many of the best minds of this generation and the next will be occupied with the relation between the biological whole and its biochemical parts. — Vincent P. Dole, M. D., New York, N. Y.: *Bulletin of the New York Academy of Medicine*, 41:211-213, February 1965.

Gonadal Dysgenesis

Report of a Case of Male Genotype with Female Phenotype — "Pure Testicular Dysgenesis"

M. BALUCANI, M.D., and D. SCHNELL, M.D.

THERE are many varieties of sexual infantilism. The classic "Turner Syndrome," with webbing of the neck, cubitus valgus and short stature has been discovered to have a 45/XO chromosome pattern.[1-3] Recently several cases have been reported in association with XO/XX[2-6] and XO/XXX[7,8] pattern and also anomalies of chromosomes such as X^{X} (deletion of long arm of one of the X chromosomes),[7] $X_{\wedge}$ (deletion of short arm of one of the X chromosomes),[8] XX (enlarged X chromosome, isochromosome)[2,8] and the mosaic XO/X^{X}[2,9] have been found in this syndrome. Occasional cases of sexual infantilism without the other anomalies described by Turner have also been found to have a 45/XO pattern.[8]

Therefore it has been found best to classify these diseases by the genetic constitution and to call them both "ovarian dysgenesis." Recently, a few cases of sexual infantilism without the classic deformities of the Turner variety have been found to possess a 46/XY chromosomal pattern.[2,10-14] This has been called "pure testicular dysgenesis."[14] These cases are apparently physically indistinguishable from the cases with an XO pattern lacking Turner anomalies and therefore present diagnostic difficulties. We are presenting an additional case of a "pure testicular dysgenesis."

Case History

This is a 17 year old Negro girl with the chief complaints of amenorrhea and failure of full external characteristic sexual development. She was born by a healthy mother who has normal menses and who delivered three other children, all males. Her height was 64 inches, her weight 136 lbs. There was sparce pubic and axillary hair and only slight breast development. The abdomen was in direct continuity with the chest (Fig. 1). The external genitalia were of the infantile type but with an apparent clitoris and a rudimentary vaginal introitus able to take a small size Sims speculum. The vaginal vault was red and several folds were present. A small nubbin of white tissue was seen in the middle of the vault. A finger examination confirmed the presence of a very small cervix. No pelvic organs or masses were felt vaginally or rectally.

Positive findings in the x-ray study were: (1) the elbows showed all epiphysis to be opened with approximate bone age of 13-14 years, (2) a spina bifida of L-5 and S-1 was found, and (3) the hysterosalpingogram showed a very small uterus with patent tubes Fig. 2. Positive findings in the Laboratory studies were: Urine Gonadotropins, were 72 units of U.R.W. X24 hours, a trace of estrone was present in the urine, and it was impossible to detect estradiol or estriol. The maturation index was negative for estrogen effect. Buccal smear was chromatin negative. A repeat chromosome examination from leukocytic culture showed 46 chromosomes with a constant XY pattern (Fig. 3).

At laparotomy primitive gonadal streaks were found. Biopsies were made of the edges and microscopic examination revealed a primitive fetal type of mesenchyme with surface cells of cuboidal appearance. Within the mesenchyme were widely scattered small abortive testicular cords and occasional islands of plump, rounded cells having the appearance of Leydig cells (Figs. 4-5-6).

Discussion

As more cases are reported in the world literature, the etiopathogenesis of "gonadal" dysgenesis becomes less and less clear. The gonadal streaks that Turner called "agenetic ovaries" have been found in the patients with tall and short stature, with or without mental deficiency, with or without pubic hair, with or without webbed neck or skeletal deformities. The true clinical entity of gonadal dysgenesis is very difficult to understand because of such variety of clinical findings. These patients usually have an elevated urinary follicle-stimulating hormone (FSH) and amenorrhea but cases with occasional menses and histologic findings of ova and follicles have been reported.[15,16] The sex chromatin pattern is in the majority of the cases a 45 XO chromosome, however several patterns of chromosomes are possible. Bahner et al.[17] reported a case of a short patient with 45/XO chromosome who had normal secondary sex characteristics, had a normal menses and had delivered a child. It would be of interest to know the chromatin pattern of this child and to follow his progress.

In the literature, cases of normal appearing fe-

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Submitted April 12, 1965.

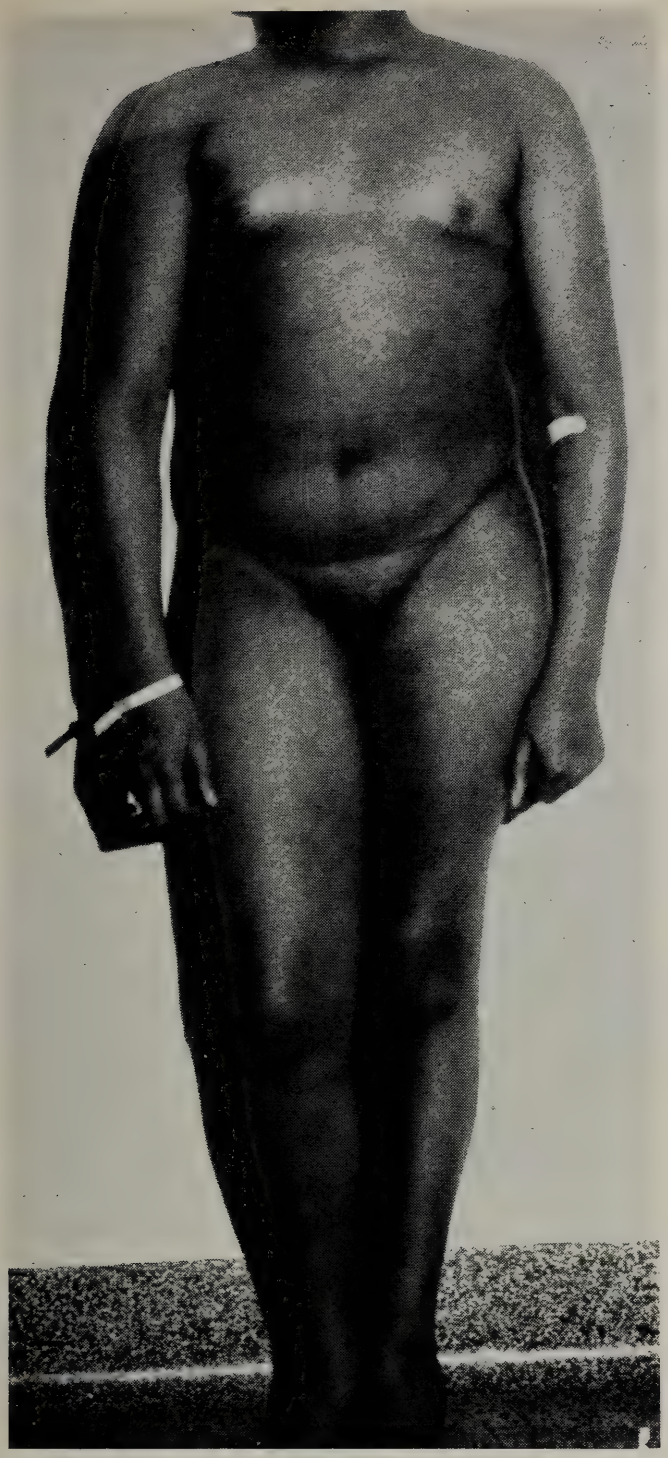


FIG. 1. *The patient. Note small breast development. Closer inspection reveals that patient has a more eunuchoid appearance with broad shoulders and narrow hips rather than true feminine.*

males with abnormal chromosomal patterns have been reported. Graham[14] noted that there is no correlation between the chromosomal pattern and the somatic manifestation, except that 45 chromosomes are more often found in the short patient. Jones et al.[18] noted that congenital anomalies are more prone in the patient with XO chromosomes. Why our patient had a spina bifida with an XY pattern is very difficult to correlate.

Of the few cases of gonadal dysgenesis with XY chromosome pattern, three had operative and histologic confirmation of the presence of primitive testicular gen-



FIG. 2. *Hysterosalpingogram showing shallow, narrow vagina, primitive uterus and thready tubal structures. The pattern is infantile.*

ital ridge, Leydig's cells, wolffian or müllerian duct remnants.[14] Graham[14] feels that "pure ovarian dysgenesis" (XO chromosome pattern) can be differentiated from pure testicular dysgenesis (XY chromatin pattern) only on the basis of chromosomal constitution, since physical and laboratory findings are similar. However, it appears that differentiation can also be made histologically (although with difficulty) on the basis of finding primitive testicular tissue such as in the case of Graham,[14]Dominguez and Greenblatt,[19] deGrouchy et al.[10] and in the present case. Occasionally, primitive ovarian tissue can be found in the typical case of gonadal dysgenesis with an XO chromosome pattern.

It has been generally accepted that the chromatin pattern present in the patient with ovarian dysgenesis is a result of nondisjunction of sex chromosomes. The presence of a Y chromosome usually gives rise to a male phenotype, regardless of the number of X chromosomes present.[20] However, the presence of a female phenotype in patients with gonadal dysgenesis having a male pattern (XY) can probably be best explained on the basis of Jost's classic experiments.[21] He showed that in the mammals

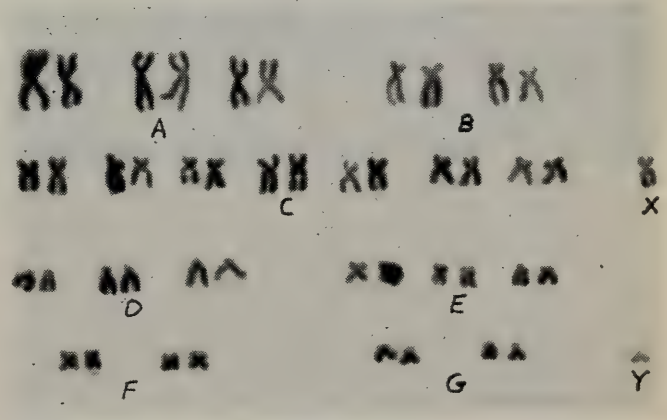


FIG. 3. *Chromosomal Ideogram showing essentially normal pattern with XY sex chromosomes.*

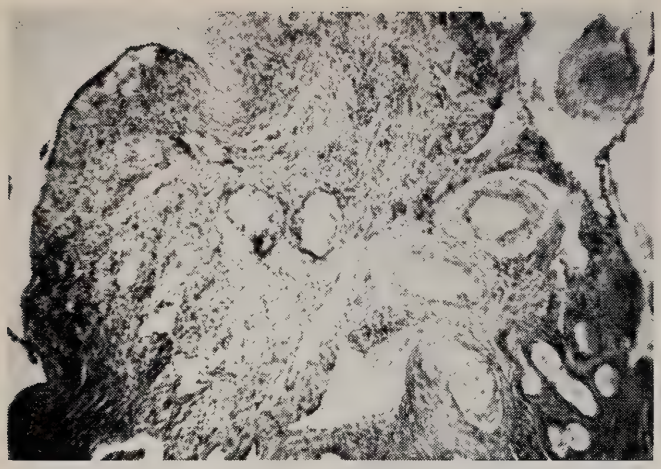


FIG. 4. *Low power view of microscopic section of ridge biopsy showing general structure of primitive, well vascularized mesenchyme. (x50)*

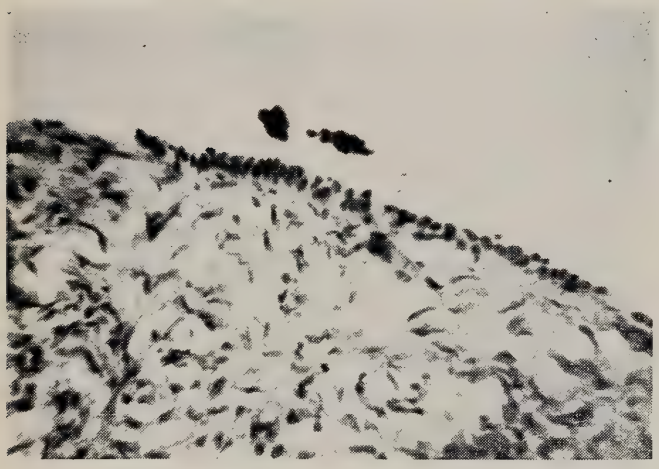


FIG. 5. *Higher power view of ridge biopsy showing detail of mesenchymal structure with surface cells assuming columnar or cuboidal shape. (x430)*

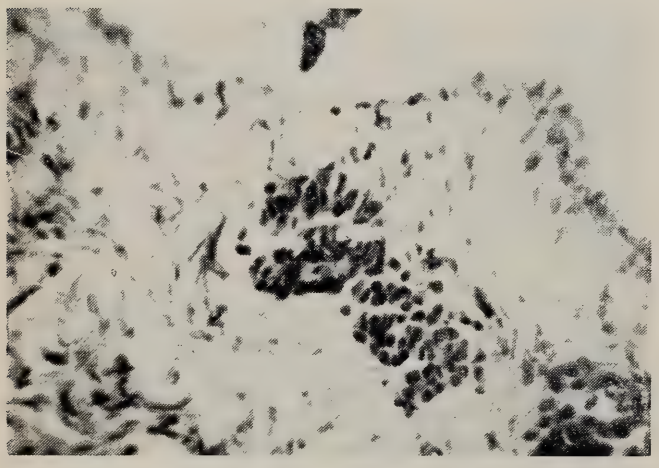


FIG. 6. *Area of microscopic section of genital ridge biopsy showing primitive testicular cord formation. (x430)*

there is a definite tendency for feminization in the absence of gonadal development or gonadal ablation in chromosomal males. His conclusion was that this probably is closely allied to the endocrine influence of the maternal organism. Thus in the absence of a normally maturing and functionary testis, a male phenotype cannot develop and the maternal endocrine influences are not overcome by the offspring.

It is, then, clear that the inherent problem is why the testis fails to develop in cases of gonadal dysgenesis with an XY pattern. To date no satisfactory explanation has been offered.[22]

Jones et al.[18] tried to explain it on the basis of lack of migration of the germinal cells to the medullary ridge. This is suggested by the experiments of Dontchakoff[23] who demonstrated the phenomenon in rabbits. However the question of why migration is arrested has not been answered. Jones et al.[18] suggested that absence of a Y chromosome or of an X chromosome inhibits migration of the primitive germ cells. Their reasoning is tenuous and does not seem applicable to cases of gonadal dysgenesis with an XY pattern since a Y chromosome is present.

Miller et al.[22] have suggested the defect may be due to the absence of some male-determining factor in the Y chromosome, providing an XO/XY mosaic pattern is not present.

In cases of gonoadal dysgenesis, either XO or XY or other patterns, histologic definition of the gonadal streak into primitive ovary or testes may be difficult to ascertain. This is due to the similar appearance of Leydig (interestitial) cells and hilar cells, the former obviously indicating testes and the latter ovary. Histologic definition therefore appears to rest on the negative finding of lack of primitive follicles or the positive finding of primitive testicular tubules. We are fortunate in seeing primitive cords in addition to the nests of large cells of Leydig or hilar type thus indicating a primardial testis rather than ovary. The findings correlate well with the chromosomal pattern.

As far as management of the patient with any chromosomal sexual anomaly is concerned, it has been generally agreed that the patient should be oriented socially according to somatic appearance and development. In this case, the patient was allowed to continue life as a female and was told only that she would be sterile.

Summary

1. It is impossible to clinically distinguish most cases of sexual infantilism without the aid of chromosome studies and perhaps laparotomy with biopsy. Many cases with a 45/XO chromosome pattern will not have the classical Turner's syndrome anomalies and will be indistinguishable from XY chromosome patterns with female somatotype.

2. The term "pure testicular dysgenesis" should be accepted as a clinical classification in patients with XY chromosome and female phenotype and with histologic findings of a primitive testes.

3. It is not known why gonadal development should fail to take place in cases of gonadal dysgenesis with an XY chromosome pattern. It has been suggested, (a) that germ cells fail to migrate

to the ridge, and (b) that there is absence of a male determining factor in the Y chromosome.

4. Management should generally follow along the line of the patient's somatic and psychologic development.

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AGE AND STILLBIRTHS. — The older the father and mother, the greater possibility that babies will be stillborn. The author analyzed records of 742 stillbirths that occurred during 1958-1961 with particular reference to parental age; an equal number of live births, occurring in 1960, were used as controls for comparison. The largest number of stillbirths (311) fell into the category of "cause of death unspecified." The mean ages of the fathers and mothers of these stillbirths were greater than those of the corresponding fathers and mothers of the liveborn. Fathers in the first group were over age 31, mothers just under age 29; among the controls, fathers were under 30 years and mothers under 27 years. In each case the difference is highly significant. In the second largest category of 262 stillbirths listed as "cause of death ill-defined," the mean age of fathers was higher than the mean age of fathers of the controls — over age 30 versus under age 30. Mothers were actually younger than those in the control group, giving support to the hypothesis that advancing paternal age is significant.

While several explanations can be given for the relationship between stillbirth rate and maternal age, paternal age effects are more enigmatic. Differential transmission of abnormal chromosomes with advancing age and the accumulation of mutations in older males may be a partial explanation. A disproportionate number of studies have been concerned with maternal age as compared with paternal age. This is partly due to lack of available data on the age of the father, but also results from a general apathy in the past toward the concept that paternal age could be of any etiologic importance for congenital malformation or stillbirth. Thus, a Los Angeles study of fetal deaths could not be compared with the Arizona findings because the age of the father was not given.

Since certain congenital malformations and stillbirth rates increase with the father's age, it is unfortunate that the father's age is not included in, or compiled from, many vital statistics and obstetrics records in the United States at the present time. Because of this unfortunate oversight, information that could be of importance for etiologic studies is not available. — ABSTRACT: Charles M. Woolf, Ph. D., Arizona State Univ.: *Obstetrics & Gynecology,* July 1965, pp. 1-7.

Chromatin Sexing in Carcinoma Of the Breast

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CARCINOMA of the breast is treated by radical mastectomy in the majority of cases. Most surgeons follow the rules set forth by Haagensen in determining operability. The therapeutic course thereafter may include irradiation, oophorectomy, androgens, estrogens, adrenalectomy, or hypophysectomy, depending upon the individual surgeon's readings, philosophies, and experience, and upon the type of tumor and the patient's particular course.

In the European literature[1-10] we now gain some new insight into what might represent additional concrete factors in our thinking. These investigators have shown that a direct correlation exists between the chromatin sex of breast carcinoma cells in women and prognosis with hormone therapy. They demonstrated that patients with Barr positive tumor cells improved with androgen therapy, whereas those with Barr negative tumor cells rapidly deteriorated.

It was our purpose to test this hypothesis on a randomly selected group of patients. Our findings are presented.

Methods

Tissues from 29 patients operated upon for breast cancer in 1957 were selected at random and sectioned at 4-5 micron thickness. No attempt was made to differentiate the tumors by the usual histologic classifications. Various staining techniques were screened in our laboratories.[11-16] Bouin fixed tissues were used in our study, therefore the stains employed by the European workers proved to be unsatisfactory.[3,7] The Guard stain finally was selected.[12] Using this method, the slide is stained with Biebrich scarlet, which colors all nuclear chromatin material. The preparation is then overstained with Fast Green which displaces all the scarlet color except that in the chromatin body and the nucleolus. Two hundred and fifty neoplastic cells from each cancer were examined for the presence or absence of nuclear chromatin. Classification of tumor cell type was accomplished as noted in Table 1.

If 20 per cent or more of cells contained Barr bodies, they were classified as Barr Positive. A designation of Barr Negative was given for a 6 per cent or less count. The intermediate zone was simply called undetermined. Barr positive and Barr negative cells are loosely referred to as female and male, respectively.

The findings were then correlated with the status of each patient up to seven years post-mastectomy (as data were available) and with the treatment program employed.

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TABLE 1. *Criteria for Chromatin Sexing*

	% of Cells with Barr Bodies	Sex of Tumor
Barr Positive	greater than 19.9	Female
	6.1-19.9	Undetermined
Barr Negative	less than 6.1	Male

Results

Thirty-three per cent of the tumors studied contained Barr negative cells, 50 per cent of the tumors contained Barr positive cells; in the remainder the cell type could not be determined (Table 2). These

TABLE 2. *Breast Carcinoma*

	Cohn-Wykoff Cases	%	Mitterauer Cases	%	Ehlers Cases	%
Barr Negative tumors	10	33	45	31	25	33
Barr Positive tumors	15	50	59	41	50	67
Undetermined	5	17	39	28		

percentages correlate well with the results of the European studies. Note that Ehlers gives only a single figure for the combined Barr positive and undetermined sex. These may all be subsequently classified as Barr positive.

Considering only the Barr negative (or male type) carcinomas in our series, two of the three treated with androgen or oophorectomy were dead within five years while only one of seven treated with no hormone therapy was dead (Table 3). Although these numbers are small, the results are compatible with the European conclusion that androgen therapy (or oophorectomy) stimulates breast carcinomas with Barr negative cells.

Regele, Domanig, and Lorbek[5] found that when patients with Barr negative and Barr positive cells

TABLE 4. *Clinical History in 29 Patients and the Frequency of Nuclear Chromatin in Tumor Cells*

Case Number	Mastectomy	X-Ray Rx.	Hormones	Oophorectomy	Survival	Frequency of Chromatic Sex Nuclear Chromatin	
1	Radical	No	No	No	7 yrs. Living	24.8%	F
2	Radical	No	No	No	7 yrs. Living	20%	F
3	Radical	No	No	Yes	4 yrs. Living	23.3%	F
4	Radical	No	No	No	6 yrs. Living	12.8%	U
5	Radical	No	No	No	3 yrs. Dead	22.4%	F
6	Radical	No	No	No	7 yrs. Living	6%	M
7	Radical	Yes	No	No	5 yrs. Living	6%	M
8	Radical	No	No	Yes	5 yrs. Living	4.8%	M
9	Radical	No	No	No	6 yrs. Living	28.4%	F
10	Radical	No	No	No	5 yrs. Living	26.8%	F
11	Radical	....	....	....	6 yrs. Living	13.2%	U
12	Radical	No	No	No	6 yrs. Living	3.2%	M
13	Radical	No	No	No	5 yrs. Living	30.0%	F
14	Radical	No	No	No	5 yrs. Living	6.0%	M
15	Radical	Yes	Yes	No	2 yrs. Dead	3.2%	M
16	Radical	Yes	Yes	Yes	2 yrs.	36.8%	F
17	Simple	Yes	Yes	No	1 yr. Dead	2.4%	M
18	Radical	No	No	No	5 yrs. Living	26.0%	F
19	Radical	No	No	No	7 yrs. Living	26.0%	F
20	Radical	No	No	Yes	7 yrs. Living	35.2%	F
21	Radical	No	No	No	6 yrs. Living	22.8%	F
22	Radical	No	No	No	7 yrs. Living	14.4%	U
23	Radical	No	No	No	5 yrs. Living	5.2%	M
24	Radical	....	....	....	3 yrs. Living	31.2%	F
25	Radical	Yes	No	No	7 yrs. Living	10.4%	U
26	Radical	No	No	No	5 yrs. Living	3.6%	M
27	Radical	Yes	Yes	No	4 yrs. Living	11.6%	U
28	Radical	Yes	No	No	6 yrs. Living	3.2%	M
29	Radical	Yes	Yes		3 yrs. Living	39.5%	F

TABLE 3. *Patients with Barr Negative (Male) Carcinomas*

	Hormone Therapy (Testosterone or Oophorectomy)		No Hormone Therapy	
	Cohn-Wykoff	Regele[5]	Cohn-Wykoff	Regele[5]
Dead	2	13	1	6
Living	1	6	6	17
Total	3	19	7	23

were treated in similar fashion with radiation and usual hormone therapy, 13 of 19 were dead in the former as compared to 4 of 24 in the latter.

The clinical history in the 29 patients in our study and the frequency of nuclear chromatin in tumor cells are summarized in Table 4.

Discussion

The findings in our small, and probably not statistically significant, study are compatible with those described earlier by our European colleagues. A definite correlation seems to exist between the cell type of the carcinoma and its response to hormonal therapy. These data would indicate that a Barr negative tumor treated with androgens or oophorectomy would be expected to deteriorate rapidly. A Barr positive tumor might be expected to do well on this same type of therapy.

It is not our purpose to recommend these findings as a guide or timetable for treating this type of patient. We merely propose an interesting correlation, which probably warrants further extensive investigation combined with a prospective study. It must be pointed out that we cannot attempt to predict the results of a similar study in which the histologic classification is taken into consideration. The techniques of preparing the slides and interpreting them were not difficult and could be utilized in any general hospital.

Summary and Conclusions

Our data and the findings of others suggest that the five-year survival is shortened in patients with breast carcinoma characterized by a low percentage of Barr positive tumor cells when treated with androgens or oophorectomy. Although further study is indicated in this area, the use of androgens in a patient with a Barr negative tumor cell type would seem tenuous at this time.

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DEATH BY DEFAULT. — The public must be protected of course, but isn't there such a thing as over-protection? Certainly it is no problem to prevent the introduction of any drugs with potentially harmful or mildly harmful side-effects. It's simple — just don't develop any new drugs, or at least make it very difficult for a new drug to be tested and/or marketed. The only difficulty here is that many lives and the improved health of many others would be lost by default, that is, drugs that could be of benefit would never be developed. This is just as wrong as allowing anything and everything to be pushed onto the drug market. For the non-medically orientated it is quite easy to understand the sad results of a thalidomide deformed baby but far less easy for many to comprehend the equally sad results of those lives that can be lost by default. — Joseph P. Schaefer, M. D., *New Physician*, 13:10, (Oct.) 1964.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

COLIN R. MACPHERSON, M. D., *President*

PRESENTATION OF CASE

A WHITE HOUSEWIFE, aged 21 years, was admitted to Ohio State University Hospital with the chief complaint of severe shortness of breath. She had "lung trouble" at birth and had asthma as a child. Since age 10 she had had many hospitalizations elsewhere for shortness of breath that occurred at rest, and her physical activity had been severely limited because of dyspnea. Two years prior to admission she delivered a 7-month premature infant and noted no marked increase in her respiratory symptoms during the pregnancy. Beginning nine months prior to admission the patient developed recurrent pedal edema, edema of the thighs, vulva and abdomen, and had been bedfast at home during these periods.

She had a chronic cough usually productive of large amounts of purulent sputum and occasional episodes of mild hemoptysis. Her medications for an unknown period of time had included Meticorten®, digoxin, and Aldactone®. About four weeks prior to admission the patient was told that her liver was enlarged, and she noted right upper quadrant tenderness, clay-colored stools, and yellow skin and eyes that remained for two weeks. The patient denied any allergies, had no previous operations, and had had whooping cough, measles and mumps in childhood. There was no family history of diabetes, hypertension, heart or lung disease.

Physical Examination

The patient was a frail, childlike white woman in acute respiratory distress, showing cyanosis and shallow, rapid respirations. Her pulse rate was 120 per minute and regular, blood pressure 80/60, respiratory rate 32 per minute and shallow. She was afebrile. The skin had poor turgor, and an acneiform rash was noted on the face. Examination of the head, ears, eyes, nose and throat was not remarkable except for a perforated anterior septum of the nose. Examination of the neck revealed no venous distention or masses; the thyroid was not palpable. The chest had an increased anteroposterior diameter and accessory muscles were used in breathing. Coarse rales were heard throughout the lung fields with tubular breath sounds throughout and occasional inspiratory and expiratory wheezes.

The point of maximal impulse of the heart was in the fifth left intercostal space at the midclavicular line. The rate was 120 per minute and regular. No heaves or thrusts were described and no murmurs or friction rubs were noted. A protodiastolic gallop was noted on inspiration. The abdomen was soft and not distended; there was no ascites present. The liver was palpable 2 cm. below the costal margin. The spleen was not palpable. Examination of the extremities revealed 2 plus pitting edema of the ankles and pretibial areas and peripheral cyanosis. No clubbing was described. The neurological examination was within normal limits.

Laboratory Data

On admission, her hemoglobin was 11.4 Gm.; the white blood cell count was 32,000 (neutrophils 75 per cent, lymphocytes 21 per cent, eosinophils 1 per cent). The urine had a specific gravity of 1.009, contained 50 mg. of protein, and was otherwise normal. The blood chemistry findings were: CO_2 combining power 23 mEq./L., sodium 149 mEq./L., potassium 5.9 mEq./L., chlorides 99 mEq./L.; urea nitrogen 24 mg./100 ml.; sugar 30 mg./100 ml.; total bilirubin 0.1 mg./100 ml.; total protein 7.1 Gm./100 ml. (4.6 Gm. albumin, 2.5 Gm. globulin); plasma cortisol 20.3 mcg./100 ml. Repeat fasting blood sugars were 53 and 82 mg. Serum protein electrophoresis was essentially normal except for a slight increase in the gamma fraction. Repeated sputum cultures were negative for acid-fast organisms and revealed only a light growth of normal flora. Histoplasmin complement fixation and agglutination tests were negative.

On chest x-ray, the heart was moderately enlarged with prominence of the right ventricle and of both pulmonary arteries. Both lung fields showed severe

Presented by

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Edited by Dr. von Haam.

Submitted October 26, 1965.

emphysema with numerous large blebs and bullae. There was partial consolidation of both upper lung fields with upper retraction of both hilar areas; the minor fissure was also retracted upward on the right. Upper gastrointestinal examination revealed no lesions of the esophagus, stomach or duodenum. Repeat chest x-rays confirmed the cardiomegaly, the prominence of the pulmonary artery segments, cystic changes of the lungs, and linear fibrosis in both upper lung fields.

The electrocardiogram revealed right axis deviation and probable right ventricular enlargement.

The results of pulmonary function studies were: maximal breathing capacity 21.7 L./min. (23 per cent), vital capacity 1,273 cc. (42 per cent), 1 sec. forced expiratory volume 527 cc. (21 per cent). Arterial gas studies done shortly after admission revealed O_2 saturation 83.9 per cent with an O_2 content of 13.63; CO_2 content of whole blood 61.5 (serum 71.2); pCO_2 54.1 mm. Hg.; pH 7.38. Sweat chlorides were 8.51 mEq./L. Sweat chlorides obtained on the patient's brother and mother were 15.38 and 27 mEq./L., respectively.

Hospital Course

This severely dyspneic patient was started on intermittent positive pressure therapy, was continued on steroids, digitalis, and diuretics, and was started on tetracycline. Initially, the patient showed improvement on this course of therapy. It was decided that a scalene node biopsy should be performed to aid in the diagnosis of her chronic pulmonary problem. After receiving barbiturate and Demerol® as preoperative medication, the patient became severely cyanotic and hypotensive. Several days later scalene node biopsy was performed and the pathology report was that of an essentially normal lymph node.

Postoperatively, a remarkable change was noted in the patient's behavior and she became definitely paranoid. She also developed a fever and penicillin therapy was started. From that time on, her behavior was very unpredictable; at times she would be cooperative and normal, at other times frankly psychotic with hallucinations. It was thought to be a functional psychosis, probably schizophrenia, paranoid type. She progressively deteriorated and became uncommunicative. During the succeeding days she continued to follow this unpredictable course and lapsed into periods of catatonia. She was maintained on intravenous fluids and antibiotics. The respiratory status progressively worsened, necessitating tracheostomy.

Approximately 24 hours prior to her death she began to have ventricular tachycardia that rapidly went to ventricular fibrillation and cardiac arrest. She was resuscitated several times during the course of the next 24 hours. The patient died after 33 days of hospitalization.

CLINICAL DISCUSSION

DR. BRASHEAR: In essence, this was a 21 year old housewife who was admitted here for the first time with severe shortness of breath. She allegedly had had lung trouble since birth. I want to comment here that this is hard to evaluate. It seems she had been in the hospital many times for shortness of breath. "Many" times could have been two times, it could have been ten times a year. It could have been shortness of breath because of lung disease that would show on an x-ray, or it could have been shortness of breath because of episodes of asthma with a normal x-ray. Nine months before admission she developed some purulent sputum, had some peripheral edema, and was treated with the usual medications. She continued along and four weeks before admission she had some type of episode in which her liver got large and apparently she was jaundiced and had some tenderness in the right upper quadrant.

On the examination here she appeared to be in severe distress. She was cyanotic and they described her as being pale and childlike. I would say from this description that she was probably underdeveloped, malnourished, and appeared chronically ill. She had a perforated anterior nasal septum. I am not sure why this was in there unless they are trying to suggest that she had Wegener's granulomatosis. I don't think she did, but I thought I'd mention it. Examination of her lungs and heart showed nothing really spectacular. The liver was enlarged and she had other findings of right-sided failure.

As far as the laboratory data go, she had an elevated white count and a little protein in the urine. Her blood electrolytes weren't remarkable. The blood urea nitrogen was up just a very little. Her blood sugars were a little on the low side. Her gamma globulin was slightly up, which is interesting for several reasons that I will mention later. The plasma cortisol was within normal limits. The electrocardiogram described cor pulmonale. The pulmonary function studies revealed that she was indeed pretty sick. Her vital capacity and maximum breathing capacity were markedly decreased. She must have had a lot of lung disease and she was unable to get much expansion out of her lungs. The arterial blood studies show that she was quite desaturated. She was also unable to get rid of all the CO_2 she was producing and she was just a little on the acid side. Her sweat chlorides were not elevated.

While in the hospital she was given the usual group of medicines, which didn't help much, and they decided to do a scalene node biopsy. This woman was in very marginal respiratory condition and they gave her some barbiturate and Demerol, which I would anticipate was probably a touch too much and it tipped her over on a rapid downhill course. They managed to pull her through this decline in order to snatch out a scalene node several days later, which didn't show much. She developed an acute toxic psychosis, went on a downhill course and died. May we see the films now?

DR. DUNBAR: The films of her chest demon-

strate quite nicely pulmonary emphysema with large bullous areas throughout the bases. In addition, one has a feeling that there is considerable peribronchial thickening throughout the more normal upper lung fields, and the entire picture is quite consistent with a diffuse pulmonary fibrotic process. It is a very nice picture for chronic pulmonary disease with secondary cor pulmonale with right ventricular and main pulmonary artery enlargement due to obstruction of blood flow through the lungs. Since she was a young individual, it would make a fine diagnosis of cystic fibrosis of the pancreas with chronic infection and fibrosis of the lungs.

DR. BRASHEAR: I think the first thing that is unusual about this patient is that she was a 21 year old woman who died of chronic lung disease. First I thought of something of a congenital nature, such as congenital bullae, but to have symmetrical congenital bullae is not a very strong possibility. The other thing that occurred to me was whether or not there was some abnormality in the blood supply to the lower lobes that had produced hypovascularization. This is a remote possibility. There are recent case reports on congenital absence of the pulmonary artery and on congenital stenosis of the branches of the pulmonary artery, and almost any branch or branches of the pulmonary vessels can have stenosis. But it's hard to believe that she had bilaterally symmetrical lesions of the pulmonary vessels causing hypovascularization. There is the possibility that she had some type of hypogammaglobulinemia and chronic infection, but the protocol says that the gamma globulin was somewhat elevated. As far as congenital diseases go, I don't have much more to offer.

Neoplasm?

As for the neoplasms, there is a history that covers this long period since childhood, so I wouldn't want to consider this. As far as infection goes, again I can't think of anything that I would want to mention. I have a lot of respect for tuberculosis; I think it can mimic anything. But she was examined for tuberculosis and no bacilli were found. Any other infection I really can't get too enthusiastic about.

So I end up with "miscellaneous" diseases and I shall spend some time talking about them. Again I would mention Wegener's granuloma just in passing since I really don't place much weight on it. The other thing I thought about was sarcoid and this patient could indeed have had sarcoid. Sarcoid, in my opinion, can give any type of x-ray; it can give nodes alone, it can give miliary disease, and some people feel that it can produce cavities. To say something is not sarcoid on the basis of a chest x-ray is dangerous. Sarcoid usually begins around the age of 18 to 20 and so, just on the basis of age alone, the diagnosis of sarcoid would be somewhat tenuous. Also in sarcoid anywhere from 60 to 80 per cent of the lymph nodes ought to be positive for sarcoid.

The first time I read this through my first two diagnoses were sarcoid and fibrocystic disease of the pancreas, and the second time I read it through I thought only of fibrocystic disease, but the more I read about fibrocystic disease the less probable this diagnosis became. This is an exocrine disease that involves the pancreas, liver, sweat and salivary glands. Ninety per cent of the people with fibrocystic disease die from respiratory failure. They develop episodes of bronchial obstruction and infection, episodes of severe dyspnea, and after this they develop obstructive emphysema with poor aeration of the alveoli, decreased oxygen saturation and CO_2 retention not unlike this patient. They also get septicemia when they have these episodes of bronchial obstruction and infection. They are also subject to episodes of massive atelectasis, and they are also subject to sudden death from asphyxiation from great globs of mucoid type secretions. About 2 per cent of people with fibrocystic disease get liver disease, which may present as cirrhosis, hepatosplenomegaly and portal hypertension.

Fibrocystic Disease: Criteria

There are usually *four diagnostic criteria* to make the diagnosis of fibrocystic disease. The *first* one is pancreatic deficiency; 80 to 90 per cent of the people have absence of pancreatic exocrine function. The *second* criterion is pulmonary disease with obstructive emphysema and chronic bronchopneumonia, which this woman did have. The *third* criterion for the diagnosis is an abnormal sweat test, and only very few patients do not have it. Her sweat test and the sweat tests of her brother and mother were certainly normal. The chloride level to be abnormal should be around 60 to 70. The *fourth* diagnostic criterion is the occurrence of the disease in siblings or in the family history, which apparently she didn't have. So out of these four diagnostic criteria she had one for certain and the pancreatic deficiency we really can't say a whole lot about.

The fate of the people with fibrocystic disease is determined by their pulmonary disease. Most of the people with fibrocystic disease do not live this long. Out of one series of 550 patients only 106 survived beyond the age of 10, and the oldest out of this series was 24. Ninety per cent of them died from pulmonary disease. I think fibrocystic disease in this patient can be considered, but from a statistical standpoint I think everything is really against it except the clinical course and the chest x-ray.

I am now running out of possibilities and so I come to the very loose term of pulmonary fibrosis. The possibility that she did have fibrosis of some type exists. Hamman and Rich described their syndrome in 1933, 1935, and 1944 as a very peculiar progressive diffuse fibrosis of the alveolar walls with dyspnea and right heart failure. They only described four cases, and their patients survived 31 days to 4 months. Some of the features of this diffuse interstitial fibrosis are dyspnea, dry cough, rales at the

bases, weight loss, clubbing of the fingers, and signs and symptoms of right heart failure. The term *Hamman-Rich* should be used for the acute fulminating form, which has a strong predilection for the lower lobes with decrease in volume. Again it would be hard for me to say that this woman had bilaterally symmetrical diffuse interstitial fibrosis, but the possibility does exist.

There is an excellent review in the *Quarterly Journal of Medicine* of January, 1964 on diffuse interstitial pulmonary fibrosis based on 45 patients. Dr. Scadding in England, who was a visitor here a couple years ago, has brought out a new term for diffuse interstitial fibrosis. He recommends that this disease be called *fibrosing alveolitis*. In this manner he wishes to indicate that it is primarily a disease of the alveolar walls as opposed to an organizing pneumonia with the exudate inside the alveoli. He feels nevertheless that the Hamman-Rich syndrome is still an appropriate term for patients with the rapidly fatal form of the illness. I am sure we are going to hear more about the term fibrosing alveolitis.

After discussing all these things, I am not sure what this patient had. Everything I have talked to you about, I have, in my opinion, been able to rule out reasonably well. She either had something very unusual or she had something like a nonspecific chronic lowgrade infection of some type that I have not been able to figure out, or I could say that she probably had the chronic form of fibrosing alveolitis. She had it at a young age, if the history is valid, and it's been there for a long time. If the history is not valid and this x-ray picture and her symptoms were of a lot more recent onset, she may indeed have had the Hamman-Rich syndrome. So that is probably the diagnosis I would prefer at the present time.

General Clinical Discussion

DR. GREENBERGER: It seems that you are placing a lot of reliance on the fact that the sweat test was negative. It should be pointed out that this patient was on prolonged cortical steroid therapy. The question could be raised, What effect might this have on the sweat test?

DR. ELIZABETH RUPPERT: Being on steroids will not interfere with the sweat test if you have fibrocystic disease. Adrenal insufficiency will give you abnormal sweat electrolytes and give you a false positive.

DR. GREENBERGER: There is one other thing that remains a little mysterious and that's the episode of jaundice that apparently took place before she came in, and I was wondering if you would care to expand a little on this as to what you think the possibilities might be?

DR. BRASHEAR: Apparently when she was in the hospital the bilirubin was reported as normal, and I made some comment in passing about the fact that cystic fibrosis does involve the liver on rare occasions. Except for that, I really just don't have much to add.

DR. GREENBERGER: The possibilities would be (a) that she had incidental virus hepatitis, (b) that she might have received a drug and had transient intrahepatic cholestasis with dark urine and light stools and transient jaundice, but this wouldn't account for the fact that her liver appeared to be enlarged. The third possibility might be that she had an associated episode of increased failure at the time.

DR. BRASHEAR: Oh, I think she definitely was in right heart failure with a big, tender liver.

DR. SASLAW: I would like to have this toxic encephalopathy that she had discussed a little more. Which toxins and what other types of things can give these cerebral manifestations in a patient with this disease?

DR. BRASHEAR: The psychiatrists I have known to use the term toxic encephalopathy have used it to describe people who are critically ill and become psychotic, and they call it toxic psychosis probably more for the sake of terminology than for the fact that there is an actual toxin. This woman was hypoxic and critically ill and I wouldn't want to specify any toxin. I just think this was a terminal event and may have been due to the hypoxia.

DR. SASLAW: The reason I asked that is because it is mentioned that she showed catatonia. Classical cases of catatonia have subsequently shown that they had a cerebral lesion of some sort.

DR. ATWELL: Before the days of the sweat test we probably would have been at a loss to make a diagnosis here because actually it's only since the sweat test that many patients of this age have been diagnosed as having cystic fibrosis. Certainly her history of chronic recurrent infections goes along with this condition as we know it now. There is no description of the characteristics of the secretions that she was putting out and this would be quite helpful in your diagnosis here. The sputum in these patients is so characteristic that almost by looking at it you think of cystic fibrosis. It is so thick and sticky that you can turn the box upside down and it won't even budge. The upper lobe distribution also is something that would be compatible with cystic fibrosis. In the teenagers that we have seen, almost classically these people get peculiar and nondescript infiltrations not unlike this, but it usually starts in the right upper lobe for some reason or other.

DR. DUNBAR: If we see a 3 month old baby with an atelectatic right upper lobe on an x-ray we say, "Atelectasis of the right upper lobe, rule out cystic fibrosis of the pancreas."

DR. GREENBERGER: Why don't we go ahead and observe the pathology and then I hope we will have a little time for some questions afterwards.

CLINICAL DIAGNOSIS

1. Chronic fibrosing alveolitis.
2. Acute diffuse pulmonary fibrosis (Hamman-Rich).
3. Cor pulmonale with right heart failure.

PATHOLOGICAL DIAGNOSIS

1. Cystic fibrosis involving lungs and pancreas.
2. Cor pulmonale with congestive heart failure.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The autopsy showed an underdeveloped, poorly nourished female with a puffy face, marked cyanosis of the nail beds, and venous distention. The heart showed marked hypertrophy of the right ventricle, which measured 7mm. in thickness. The pulmonary arteries showed atheromatous plaques. The lungs showed a few emphysematous blebs, congestion at the bases, and diffuse areas of fibrosis bilaterally. The trachea and bronchi were filled with tenacious mucus which could be easily pulled out with the forceps from the smaller bronchi. The combined weight of the adrenals was 6 Gm. and they showed marked cortical atrophy.

Microscopic examination confirmed the marked hypertrophy of the right heart muscle. Examination of the bronchi showed a very hyperplastic papillomatous mucosa with markedly increased mucus excretion by the epithelial cells. The smaller bronchi appeared ulcerated and surrounded by areas of inflammation. There was no muscular hyperplasia present as commonly found in asthma. Many areas of the lung showed complete atelectasis with old and recent hemorrhages. The lymph nodes showed diffuse reticulum-cell hyperplasia and at the same time a peculiar paucity of lymphocytes. Absence of lymphocytes has been stressed in this condition as a cause for subsequent infection. The small bile ducts were also obstructed by mucus, which could explain the transient attack of jaundice. In the pancreas all small ducts were obstructed by this very thick mucoid material, but no atrophy of the acinar cells was as yet noticeable.

In conclusion, we feel that we have indeed a case of cystic fibrosis, involving primarily the lungs and pancreas, that is remarkable in that it showed a negative sweat test and no clues in the family history.

Closing Remarks

DR. GREENBERGER: Recently Dr. Rubin at the University of Washington and others have shown that rectal biopsy is a very reliable means of making the diagnosis of cystic fibrosis, and they have reported that about 60 to 80 per cent of their patients with known cystic fibrosis have an abnormal rectal biopsy. The crypts are dilated with very wide mouths and they are filled with mucus. I think this case demonstrates that one sweat test is probably not sufficient because of the possibility of technical errors in making the test. I think this is a very fascinating disorder and one can raise the question as to what the basic pathophysiology is.

DR. RUPPERT: The recent knowledge I have about this is that there is an abnormal mucoprotein in the duodenal aspirate from people with cystic fibrosis that forms an insoluble precipitate with alcohol and benzene.

DR. SASLAW: I would like to ask Dr. Ruppert if the trypsin test is still of some assistance in screening.

DR. RUPPERT: Yes, we still do the trypsin test and in a child after 4 to 6 months of age a trypsin test is very worth while.

CYSTIC FIBROSIS. — No clearly demonstrable abnormality of adrenocortical function or corticosteroid metabolism was found in a series of 27 children with cystic fibrosis. Although there is no morphological adrenocortical involvement in the pathology of cystic fibrosis of the pancreas, the following observations in patients with cystic fibrosis are similar to those in patients with altered [adrenocortical function or] corticosteroid metabolism or both: (1) of patients studied to date, only those with Addison's disease or panhypopituitarism have a similar sweat electrolyte pattern, (2) steatorrhea and elevated sweat electrolyte concentrations have been reported in association with adrenal insufficiency, idiopathic hypoparathyroidism, and pernicious anemia, (3) corticotropin and corticosterone can lower viscosity of gastric secretions, and (4) the viscosity of duodenal fluid decreased following the intravenous infusion of corticosterone in a few patients with cystic fibrosis. If the abnormal sweat electrolyte pattern seen in children with cystic fibrosis is causally related to adrenocortical function, it may be caused by an end-organ resistance to normal levels of hormone. This concept is supported by the following reported observations: the response to salt restriction in normal subjects consists of increased urinary excretion of aldosterone and decreased concentration of sweat electrolytes, whereas subjects with cystic fibrosis show no decrease in sweat electrolyte concentration although their urinary aldosterone level increases. — ABSTRACT: Dale D. J. Chodos, M. D., et al.: *American Journal of Diseases of Children,* 110:76-80 (July) 1965.

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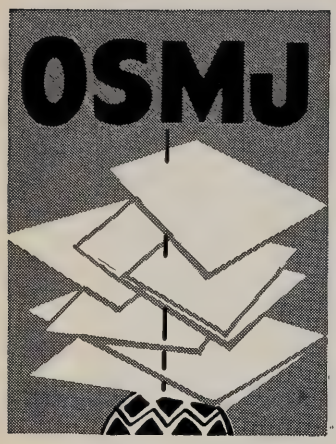
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SEARLE

Research in the Service of Medicine



NEWS AND Organization Section

AMA Philadelphia Meeting ...

Ohio Delegates Play Leading Roles in House of Delegates, Where Some of the Fundamental Principles of Medicine Were Reaffirmed

IT was November 28 - December 1, 1965, in Philadelphia but, as far as the Ohio State Medical Association delegates to the AMA were concerned, it was 1776 all over again.

Armed with resolutions and what might be called "The Spirit of '76," the Ohio delegation successfully advocated at the 1965 AMA Clinical Convention adherence to those professional principles laid down by the AMA's founders in that same City of Independence nearly 119 years ago.

Ohio's full complement of delegates and alternates, led by Chairman John H. Budd, M. D., of Cleveland, chalked up a perfect score when they gained House approval of:

1. Reaffirmation of the "usual and customary fee" **as determined by the individual physician** as the basis for reimbursing physicians for not only medicare services but also for government health programs at all levels of government.

2. Changing a Board of Trustees recommendation to read that the prevailing fee concept for medicare is "noted" rather than "approved" or "recognized."

3. A roundly applauded Ohio resolution pledging full support of Edward R. Annis, M. D., AMA's nationally known speaker against Medicare, was submitted after reports in paramedical publications alleged "top AMA officials" had apologized privately to Department of Health, Education and Welfare officials for Dr. Annis' speech at a Medicare conference held by AMA in Chicago October 1, 1965.

Model Contract Tabled

4. An Ohio resolution directing that an AMA-prepared model contract between hospitals and physicians operating emergency rooms be withdrawn and rewritten in keeping with House of Delegates policies, particularly sections of the contract calling for hospitals to bill for physicians' services and providing for a prevailing fee concept.

5. An Ohio resolution directing that AMA spokesmen who advised HEW that Medicare utilization committee "**should**" be composed of practicing physicians correct immediately this statement to conform to the House-established policies that such committees "**shall**" be composed of practicing physicians.

6. An Ohio resolution instructing the AMA Board of Trustees and officers to make every effort to encourage the voluntary health insurance industry not to cancel senior citizen contracts, to improve contracts to meet their varied needs, and not to confine the industry's efforts to writing contracts around the Medicare Law.

7. An Ohio resolution calling for an AMA Committee on future planning and development to be appointed to plan and develop where appropriate, for legislation in the health field. (Was referred to a newly created Committee on Planning and Development for study, with instructions to report back to the House in June, 1966.)

8. A resolution submitted by Dr. Meiling, requesting the Secretary of Defense to use maximum

"air lift" capabilities to return to the United States for the most effective care and treatment of American casualties in South Viet Nam, rather than developing in Japan a huge hospital complex for the same purpose, was referred to the Board for study and report back.

"Usual and Customary"

Ohio's campaign at the Clinical Convention might best be described as a war against contradictions.

Armed with the OSMA House of Delegates' support of the "usual and customary fee" concept and previous AMA House endorsements of that concept, the Ohio delegation had as one of its primary targets a Board of Trustees recommendation of approval of the prevailing fee concept as well as an AMA Council on Medical Service report, laudatory, but erroneous and misleading, on so-called prevailing fees.

Evidence of attempts to pressure the Board by the National Association of Blue Shield Plans was found in the Board's recommendation that the prevailing fee program be approved. This report cited Blue Shield's meeting with the board — requested by NABSP — to present the prevailing fee concept. It also referred to the Council on Medical Service report.

NABSP Lobbies

As prominent as a shark in a goldfish bowl were the forays of the NABSP shock troops through the headquarters hotel lobby, meeting rooms and the House of Delegates perimeter. They were so evident that some delegates asked if the convention was an AMA or a Blue Shield meeting.

The Council on Medical Service report added to the confusion by mistakenly identifying the Blue Shield prevailing fee program as a "usual and customary fee" concept. (Ohio Medical Indemnity's Newsletter to all Ohio physicians November 17, 1965, clearly explained the definite differences between the two concepts.)

The Board had recommended House approval of the concept, the Reference Committee on Insurance and Medical Service recommended that it be recognized rather than approved, but the House — on motion of Ohio — changed the recommendation so that the concept is merely "noted."

Ohio Delegation

Ohio's delegation, led by Chairman John H. Budd, M. D., of Cleveland, chalked up a perfect score in gaining House approval of Ohio resolutions and amendments.

All OSMA delegates — Drs. Budd, George W. Petznick, Cleveland; Carl A. Lincke, Carrollton; Theodore L. Light, Dayton; Edmond K. Yantes, Wilmington; Paul F. Orr, Perrysburg; Charles A. Sebastian, Cincinnati; Richard L. Meiling, Columbus; Edwin H. Artman, Chillicothe, and all alternates — H. T. Pease, Wadsworth, Robert S. Martin, Zanesville; Kenneth D. Arn, Dayton; Harry K. Hines, Cincinnati; P. John Robechek, Cleveland; Robert E. Tschantz, Canton; Frederick P. Osgood, Toledo; J. Robert Hudson, Cincinnati; Philip B. Hardymon, Columbus — were present and actively participating, as were President Crawford and President-Elect Meredith.

In the second session, Dr. Tschantz was seated as a delegate in lieu of Dr. Yantes, and Dr. Pease was seated in lieu of Dr. Petznick when those two delegates had to leave the session because of previous commitments.

The House also paid tribute in memoriam to the late Clifford C. Sherburne, M. D., an Ohio delegate for 20 years (1941-61) who died in Columbus November 13, 1965. An in memoriam resolution introduced by Ohio and approved in standing tribute appears on this page of *The Journal.*

As the result of paramedical press reports alleging that top AMA officials had apologized to HEW officials for Dr. Annis' speech October 1, given just

Dr. Sherburne Memorialized at AMA Philadelphia Meeting

At the 1965 AMA Clinical Convention November 28 - December 1 in Philadelphia, the House of Delegates adopted in standing tribute an *in memoriam* resolution presented by the OSMA delegation in honoring Clifford C. Sherburne, M. D., Columbus, an Ohio delegate from 1941 to 1961, who died November 13, 1965. Dr. Sherburne also was a past-president of the Ohio State Medical Association, the Columbus Academy of Medicine and Ohio Medical Indemnity, Inc. The following resolution was adopted by the AMA House:

PREAMBLE

Clifford C. Sherburne, M. D., of Columbus, Ohio, a member of this House of Delegates for 20 years (1941-1961), died November 13, 1965. As in all of his activities and commitments, he served as a member of this House with dedication and with an unswerving sense of responsibility.

He displayed these same high qualities in his tenure as President of the Ohio State Medical Association and as President of Ohio Medical Indemnity (Blue Shield).

Doctor Sherburne was admired and profoundly respected for his wholesome philosophy, his compassionate understanding and his unfailing willingness to serve whenever called. Therefore be it

RESOLVED, That this House of Delegates which he served so diligently and loved so well observe a moment of silence in honor of his memory; and be it further

RESOLVED, That the deepest sympathy of this House of Delegates as well as an official copy of this Resolution be conveyed to his widow.

prior to the House's special session October 2-3 and so well received that the House directed that tapes of the speech be made available to members on request, Dr. Light presented the following resolution:

PREAMBLE

Dr. Edward R. Annis, by his dedication, his unselfish willingness, and his outstanding abilities as a spokesman for medicine, has made an enormous, inestimable contribution to the profession's efforts to preserve America's system of medical care.

His complete devotion to this mission has gained for medicine — both within and outside of the profession — tremendous respect and support. He has caused the disheartened to take heart, he has spread the light of truth among the shadows of half-truths and innuendoes, and he has spread knowledge and awareness among the unaware.

One of the most important and most significant addresses in the history of modern medicine was that delivered by Dr. Annis at the Medicare conference sponsored by the American Medical Association in Chicago October 1, 1965. It was so outstanding that this House of Delegates directed that this speech be made available to the AMA membership.

Unfortunately, there have appeared in the medical news media unsubstantiated reports that so-called "key AMA leaders" were apologizing privately to Federal officials for Dr. Annis' speech. Lest there be misunderstanding, be it

RESOLVED, That the House of Delegates of the American Medical Association heartily commends Dr. Edward R. Annis for his leadership, his dedication and his tremendous contribution to medicine's campaign to preserve the world's finest system of medical care, and this House of Delegates calls on Dr. Annis to continue his mission and wholeheartedly supports him to that end.

Ohio Scores Again

The resolution drew a standing ovation in the first session of the House. The Reference Committee on Reports of the Board of Trustees, heard resounding applause after each of many witnesses testified in whole-hearted favor of the resolution. Nobody spoke in opposition to the resolution.

The Committee attempted to eviscerate the resolution by recommending adoption of only the "Resolved" portion. Dr. Light immediately moved and the House overwhelmingly passed his motion that the resolution be adopted in its entirety.

Another Ohio objective — to have rewritten to conform with House of Delegates policies the AMA-prepared model contract between hospitals and physicians operating emergency rooms — was overwhelmingly supported. The resolution directed that the model contract be completely withdrawn, completely rewritten and submitted to the House for approval prior to future circulation.

The Ohio resolution cited, as examples, two specific sections of the agreement that directly violated two major policies of the House of Delegates (and of OSMA). One section provided that the hospital should bill for the professional services of the physicians operating the emergency room. It is AMA and OSMA policy that physicians should bill for their own professional services.

Another section provided for a fee schedule based on prevailing fees in the community and nearby localities. AMA and OSMA policy provide for the usual and customary fee as determined by the individual physician providing the professional services.

Other House Actions

In other actions, the House:

- Referred to the Board of Trustees for further study recommendations from the Committee on Human Reproduction for enactment of legislation to legalize abortion and sterilization under certain conditions.
- Tentatively approved, with final House action to come at the 1966 Annual Convention next June in Chicago, a $25 increase in AMA dues.
- Approved changing the delegate ratio in the House of delegates to one per 1,250 members, when the House size reaches 250 members. Present ratio is one per 1,000 members, with total membership nearing the 250 mark.
- Directed the AMA to seek a deletion in the Medicare requirement that patient be hospitalized before he is eligible for nursing home care.
- Authorized study of constitutionality and legality of Medicare and its rules and regulations, with legal proceedings to be instituted where the Board deems advisable.
- Directed the AMA Advisory Committee on Medicare and the Heart Disease, Cancer and Stroke program to seek HEW recognition of the differences between utilization review and claims review.
- Disapproved an Association of American Medical Colleges report, particularly a section calling for the AAMC to serve as spokesman for "organizations concerned with education for health and medical sciences," a section downgrading organized professions and their associations and their role in professional education.
- Directed the Board to respond promptly to public statements discrediting medicine.
- Urged the American Hospital Association to assist hospitals in establishing a uniform system of accounting.
- Called for continued efforts, through all appropriate channels, to achieve distinctly separate billing of physicians fees and hospital fees.
- Urged creation of separate U. S. Cabinet post for Secretary of Health.
- Accepted joint opinion of Judicial Council and Council on Medical Service that physician who assumes responsibility for intern's or resident's services to a patient may ethically bill patient for services performed under physician's personal observation, direction and supervision.
- Applauded as contributions of more than $463,000 were made to the AMA Education and Research Foundation.

Also attending the meeting and assisting the Ohio delegates were OSMA staff members Hart F. Page, Charles W. Edgar, Herbert E. Gillen and W. Michael Traphagan.

American College of Surgeons . . .

Four - Day Sectional Meeting Scheduled in Cleveland For Physicians and for Graduate Nurses, March 14-17

DOCTORS and graduate nurses are invited to the twelfth annual joint Sectional Meeting of the American College of Surgeons in Cleveland, March 14-17, 1966. Headquarters hotel for doctors is the Sheraton-Cleveland, and for nurses the Statler Hilton. This is the College's only four-day meeting in 1966, and the only meeting with a program for nurses. This joint meeting pioneered in Cleveland in 1955.

Scope of the meeting approaches that of the annual Clinical Congress. In addition to sessions in general surgery there will be programs in the specialties of gynecology-obstetrics, neurosurgery, opthalmology, otorhinolaryngology, orthopedics, plastic surgery, proctology, thoracic, urology and trauma. Approximately 50 industrial exhibits will be displayed.

Nurses sessions will include discussions on surgical and nursing management of cerebral aneurysm, trends in cardiac surgery, innovations in surgical specialties, training and utilization of non-professional personnel in the operating room, and the role of the professional nurse in the operating room.

Local Chairmen

Dr. John H. Davis, Cleveland, is chairman of the advisory committee on local arrangements for the doctors' sessions. Miss Joan Gowin, R. N., Cleveland, is chairman of the nurses' planning committee. As guests of the College, nurses pay no registration fee.

Advance housing forms, giving hotel rates and registration information, may be obtained by writing to College headquarters: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

Dr. Robert J. Kamish, assistant director, Chicago, is in charge of the College's Sectional Meetings.

Speakers, moderators and panelists include numerous Ohio physicians as well as persons from near and far.

Following is a brief outline of days on which various sessions are scheduled:

General Sessions — Monday, Tuesday and Wednesday.

Orthopedic sessions — Monday and Tuesday.

Urology — Monday and Tuesday morning.

Otorhinolaryngology — Monday and Tuesday.

Plastic surgery — Monday.

Neurosurgery — Tuesday.

Thoracic surgery — Wednesday and Thursday.

Gynecology-Obstetrics — Wednesday and Thursday.

Ophthalmic surgery — Wednesday and Thursday.

Proctology — Wednesday.

Trauma — Thursday.

Sessions for graduate nurses will be held on Monday, Tuesday and Wednesday in the Statler-Hilton Hotel. Nurses also are invited to attend the session on trauma on Thursday, in the Sheraton-Cleveland Hotel.

Physicians Invited to Attend Annual Ob - Gyn Lectures in Akron

The third annual Alven M. Weil Memorial Lectureship has been scheduled in the Akron City Club, Akron, Wednesday, March 9. The program will begin at 4:00 P. M. with a three man panel presentation on "Dysfunctional Labor" by D. Anthony D'Esopo, M. D., Louis M. Hellman, M. D., and Charles H. Hendricks, M. D.

Cocktails and dinner will follow the symposium with dinner scheduled for 6:30 P. M., where the featured speaker will be Dr. Louis M. Hellman, whose topic will be "The Use of Electronics in Obstetrics and Gynecology."

The participants are all well-known in the specialty of Obstetrics and Gynecology. Dr. Hellman is professor and chairman of the Department of Obstetrics and Gynecology, State University of New York, Downstate Medical Center. Dr. D'Esopo is Clinical Professor of Obstetrics and Gynecology, Columbia University and Dr. Hendricks is assistant professor of Obstetrics and Gynecology, Western Reserve University School of Medicine.

Reservations may be obtained by writing Summit County Medical Society, Attention: Akron Obstetrical & Gynecological Society, 437 Second National Building, Akron, Ohio 44308. The Obstetrical & Gynecological group is sponsoring the lectureship under the direction of Richard J. Yoder, M. D., president, and Ronald B. Mitchell, secretary. Physicians may call the Medical Society for details to help with housing and other personal needs. Dinner reservations must be made in advance.

Proceedings of the Council ...

Tribute Is Paid to Deceased Past-President of OSMA; Several Policy and Business Matters Acted on at November 21 Meeting

A MEETING of The Council of the Ohio State Medical Association was held at 10 a. m., November 21, 1965, at the Columbus headquarters office. All members of The Council were present except Dr. Frederick T. Merchant, Marion, Councilor of the Third District and Dr. William R. Schultz, Wooster, Councilor of the Eleventh District. Others attending were: Dr. Edmond K. Yantes, Wilmington, Dr. Richard L. Meiling, Columbus, delegates, and Dr. Robert S. Martin, Zanesville, alternate delegate, to the American Medical Association; Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff.

Minutes Approved

The minutes of the meeting of The Council held September 18-19, 1965, **were approved.** Minutes of a telephone conference of The Council, held October 29, 1965, **were approved.**

Tribute to Dr. Sherburne

Dr. Fulton presented the following resolution concerning the death of Dr. C. C. Sherburne. The resolution was adopted by a standing vote and the Executive Secretary was instructed to include the text in the minutes and to send a copy to Mrs. Sherburne.

IN MEMORIAM

Clifford C. Sherburne, M. D.

President, Ohio State Medical Association,

1943-1944

The death of Clifford C. Sherburne, M. D., November 13, 1965, represents a great loss to his profession, his community and his fellow man.

As a physician, he served his patients and his profession unselfishly and with complete dedication.

As a citizen, he epitomized the meaning of citizenship.

As a person, all who knew him admired and respected him for his wholesome philosophy, his compassion and his willingness to serve when called.

As a modest and humble person, Dr. Sherburne would be the first to deny these high qualities, but these same qualities memorialize him in the minds and hearts of all who had the good fortune to know him.

Committee on Hospital Problems

The Council discussed a November 18 communication from William R. Morris, Ohio Director of Insurance, requesting that the Executive Secretary and a selected representative of the Ohio State Medical Association serve on a committee with him and with his Deputy, dealing with hospital problems. Other associations to be represented, according to the letter, are the Ohio Hospital Association; the Ohio Blue Cross Plans; and the Ohio Association of Osteopathic Physicians and Surgeons.

The Council authorized the participation of the Ohio State Medical Association through whomever the President may designate, and the Executive Secretary.

Amendment to Resolution No. 5

The Council was asked for a clarification of the last sentence of Resolution No. 5 (C 65), to be introduced by the Ohio Delegation at the 1965 Clinical Session of the AMA, at the request of The Council, as the result of action by the telephone conference October 29, 1965.

The "resolved" paragraph of the resolution reads as follows:

RESOLVED, That the House of Delegates instructs the Officers and Board of Trustees of the American Medical Association to make every effort to encourage the voluntary health insurance industry not to cancel contracts but to continue offering improved contracts to persons 65 and older. These contracts should not be written around the Medicare Law.

Initially, The Council voted to delete the last sentence, reading "These contracts should not be written around the Medicare law." Drs. Beardsley and Tschantz voted in opposition to the motion.

The Council later voted to reconsider this action. A **motion** was duly made, seconded and **carried,** that the last line of the paragraph be deleted and, in lieu thereof, the following sentence be substituted:

It is hoped that many types of contracts may be written to meet the varied needs of our senior citizens and that efforts not be confined to writing contracts around the Medicare law.

Express Confidence in Dr. Annis

On **motion** duly moved, seconded and **adopted,** the Ohio delegates to the American Medical Association were authorized to prepare and to present at the

1965 AMA Clinical meeting a resolution of confidence in the opinions expressed by Dr. Edward R. Annis.

Dr. Wilson Recommended

The Council voted to recommend Dr. Rex H. Wilson, Akron, chairman of the Committee on Occupational Health of the Ohio State Medical Association, for membership on the Council on Occupational Health of the American Medical Association.

Future Planning Committee

Dr. Richard L. Meiling presented a report from the Future Planning Committee, recommending the acceptance of the proposal to lease space for a five-year term in the "Columbus Center" building, 100 East Broad Street. The report was accepted for information.

Members of The Council inspected space available at the Huntington National Bank Building, 17 South High Street and space available at the "Columbus Center," 100 East Broad Street.

Dr. Fulton presented a report comparing the financial aspects and the various advantages and disadvantages of both locations.

After a lengthy discussion, on a **motion** by Dr. Beardsley, seconded by Dr. Diefenbach, The Council **voted** to negotiate a lease with the Huntington National Bank at 17 South High Street, Columbus, Ohio.

Attest: HART F. PAGE, *Executive Secretary*
Ohio State Medical Association

Cleveland Clinic Foundation Offers Surgery Courses

The Cleveland Clinic Educational Foundation is offering two courses on surgery of particular interest to physicians, as well as a course on pediatrics, both during January. Details may be obtained from Walter J. Zeiter, M. D., Director of Education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

On January 19 a course will be conducted on **"Vascular Surgery,"** and on January 20, a course on **"Biliary and Pancreatic Surgery,"** is scheduled. The courses in surgery are offered as a unit.

On January 26 and 27, a course is offered on **"Advance in Pediatrics."** On all courses offered by the foundation, members of respective departments of the clinic present the subject, as well as outstanding guest speakers.

* * *

A postgraduate course in **Ophthalmology** is being offered by the Cleveland Clinic Educational Foundation on January 12 and 13.

Dr. Frank C. Sutton, director of the Miami Valley Hospital in Dayton, was presented the 1965 Medical Award for Excellence in hospital administration at the annual meeting of the American College of Hospital Administrators in San Francisco.

New Provisions in OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to new provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cleveland, May 24 - 27.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 28.

The revised section in the OSMA Bylaws pertaining to the procedure reads as follows:

Section 1 (a). Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates, provided however that only those candidates may be nominated whose names have been filed with the Executive Secretary at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon filing of such candidate's name, the Executive Secretary, if such candidate is eligible for election, shall prepare and transmit this information to each member of the House of Delegates. No candidate may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the Delegates present at the opening session of such meeting. The Executive Secretary shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all eligible candidates meeting the requirements of filing and transmittal.

Deadline for Submission of Resolutions to Columbus Office of the Association Is March 25

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1966 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Tuesday evening, May 24, at the Sheraton-Cleveland Hotel, Cleveland.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 25. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting intructions from their County Medical Societies.

OSU College of Medicine Announces Short Courses for Physicians

A three-day course entitled "Electromyography IV," is one of several refresher courses offered by the Ohio State University College of Medicine.

Scheduled January 31 to February 2, this refresher course is for physicians who wish to review their understanding of the basic concepts of electrodiagnosis and familiarize themselves with the advances in the field. Neuro-physiology, instrumentation and clinical application will be included.

Additional information on this and other courses offered by the College of Medicine may be obtained by contacting the Center for Continuing Medical Education, 320 W. Tenth Avenue, Columbus, Ohio 43210. Other courses include the following:

Otolaryngology Refresher Course, January 10-14.

Management of Diseases of the Colon, February 23.

Ninth Annual Postgraduate Course in Ophthalmology, March 7-8.

The Ohio State University College of Medicine has been awarded a $132,029 grant from the U.S. Public Health Service for study of the death mechanism in acute myocardial infarction. Dr. James V. Warren, professor and chairman of the Department of Medicine, will be the principal investigator in the four-year project.

Blue Shield Plan Membership Reaches All-Time High

Membership of the 85 Blue Shield Plans in the United States, Canada, Puerto Rico, and Jamaica increased 1,029,265 during the first three quarters of 1965 to a record 57,286,041, the National Association of Blue Shield Plans reported.

Over half of the increase, 549,602, was acquired in the second quarter. The addition of a new Plan — Windsor, Ontario — contributed 263,445 members to the second quarter gain.

Included in the total enrollment figure is the membership of Medical Indemnity of America, Inc., a stock company wholly owned by the National Association of Blue Shield Plans.

During the first nine months of 1965, membership gains were reported by 63 Plans, 20 had losses, and two remained the same. Gains totaled 1,340,577, while losses amounted to 311,312.

Third quarter gains of 438,856 were posted by 56 Plans, with 26 Plans reporting losses of 129,412. Three Plans showed no change.

The 1.83 per cent enrollment increase in the first nine months brought Blue Shield coverage in the United States to 27 per cent of the population.

Blue Shield now covers 26.8 per cent of the Canadian population, 1.4 per cent of the Jamaican population, and 4.1 per cent of the population of Puerto Rico.

APPLICATION FOR SPACE, SCIENTIFIC AND HEALTH EDUCATION EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 1966 ANNUAL MEETING, SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 24 - 28

1. **Title of Exhibit:** _____

2. **Name(s) of Exhibitor(s):** _____

_____

Institution (if desired): _____

City _____

3. **Do you have a built-in exhibit?** _____

4. **Description of Exhibit: (Attach 200 word description to this blank)**

5. **Exhibit will consist of the following: (Check which)**

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____
(Describe)

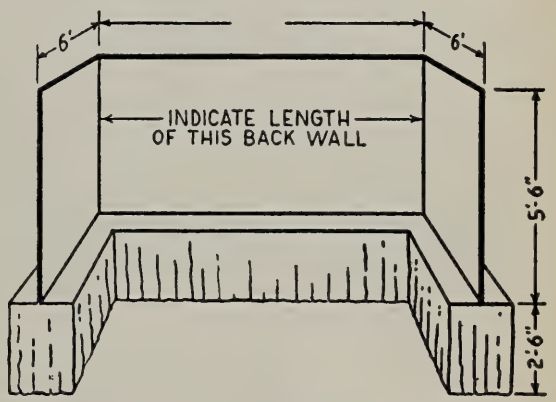
6. **Booth Requirements:**

Amount of wall space needed? _____

Back wall _____ Side walls _____

Square feet needed? _____

Shelf desired? (yes or no) _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

7. **Transparency Cases:**

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

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(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date _____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND HEALTH EDUCATION EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS, OHIO 43215

DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1966

M. D.'s in the News

Dr. William S. Kiser, Cleveland, addressed the Lorain Rotary Club where he described work being done at the Cleveland Clinic in the field of organ transplants.

* * *

Dr. Esther C. Marting, director of oncology at Christ Hospital, Cincinnati, discussed "New Developments in Cancer Control," in one of a series of public education programs sponsored by the Public Library and Public Health Federation.

* * *

Dr. Jack C. Lindsey spoke to members of the Kenton Rotary Club on the subject of the patient-doctor relationship.

* * *

Dr. William D. Monger, practicing physician of Lancaster, has been elected a director of Motorists Mutual Insurance Company, Columbus.

* * *

Dr. George Packer, director, and Dr. R. A. McLemore, president of the Clark County Medical Education Foundation, described the operation of the education program in the Springfield area at a meeting of the staff of St. Charles Hospital in Toledo.

* * *

Dr. Allen Walker, of Cleveland, recently discussed "Sun Exposure" at a Ski Seminar sponsored by the Chautauqua County (New York) Medical Society. The program is believed to be the first of its kind held for physicians and dealing with physical problems in connection with skiing.

* * *

Dr. Claude S. Beck, Cleveland, was honored at a dinner and reception, primarily attended by former patients of his who made the trip to Cleveland from near and far.

* * *

Lt. Colonel Benjamin W. Gilliotte, a practicing physician in Zanesville, recently received a certificate in behalf of his unit, the 522nd Medical Service Flight at Lockbourne Air Force Base, citing the unit for outstanding recruiting and for maintaining a good retention program.

* * *

Dr. Elden C. Weckesser, Cleveland, class of '36, is the new president of the Western Reserve University Medical Alumni Association. A practicing surgeon, he is clinical professor in the medical school, and a director of the Academy of Medicine of Cleveland. Other officers are Dr. Eugene A. Ferreri, South Euclid, first vice-president; Dr. George M. Wyatt, Iowa City, Iowa, second vice-president; and Dr. William L. Huffman, Lakewood, secretary-treasurer.

Bureau of Workmen's Compensation Desperately Needs Doctors

The Ohio Bureau of Workmen's Compensation is desperately in need of physicians to work on a full-time or part-time basis. Men are needed to work in the medical section of the Bureau, either in Columbus or in one of the other cities where facilities are maintained.

Physicians are needed to help examine and designate disability, especially percentage disability of workmen's compensation cases. The work also includes the writing of reports, reviewing of cases, evaluation of medical testimony, reviewing bills on drugs, hospital costs, nursing services, etc.

Physicians interested in either full-time or part-time work in this line are invited to contact Raymond B. Hudson, M. D., Chief Medical Officers, Bureau of Workmen's Compensation, State of Ohio, 65 South Front Street, Columbus, Ohio 43215.

It is interesting to note that a general increase in salary has been authorized in the four categories of physicians' positions. The salary scale is as follows:

W. C. Physician I, PR 45 ..... $ 860 to $1,020
W. C. Physician II, PR 49 ..... $1,020 to $1,200
W. C. Physician III, PR 51 ..... $1,100 to $1,320
W. C. Physician IV, PR 53 ..... $1,200 to $1,440

Dr. Robert Kuba was guest speaker when members of the Women's Civic League met in Uhrichsville. He discussed "Sex Education for Children."

* * *

Dr. Nicholas G. DePiero, Cleveland, has been named president-elect of the American College of Anesthesiologists.

* * *

Dr. John C. Ullery, professor and chairman of obstetrics and gynecology in the Ohio State University College of Medicine, has been awarded a renewal grant of $11,505 from the U. S. Public Health Service. It will support additional research on carbonic anhydrase in endometrial tissue.

* * *

Dr. Charles L. Hudson, Cleveland, President-Elect of the American Medical Association, was featured speaker for a meeting in Lima sponsored by the Optimist Club and including members of several other local service clubs.

* * *

After participating in the International Pediatric Congress in Tokyo, Dr. Frederic N. Silverman, professor of pediatrics and radiology at the University of Cincinnati, is serving a tour as visiting professor at several children's hospitals in Australia.

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Ad Astra

Henry Alexander Bradford, M. D., Denver, Colorado; University of Cincinnati College of Medicine, 1938; aged 52; died November 6. A native of Cincinnati who took most of his medical training in that city, Dr. Bradford began practicing in Colorado after serving in the Army Medical Corps during World War II. Among survivors are his widow and three children.

Wayne Wilson Dutton, M. D., Athens; Medical College of Virginia, 1947; aged 41; died November 23; member of the Ohio State Medical Association, and the American Psychiatric Association. A resident of Athens since about 1950, Dr. Dutton was on the staff of the Athens State Hospital before going into private practice in that city. Survivors include his widow, Dr. Genevieve G. Dutton; his mother, a brother and two sisters.

Lloyd King Felter, M. D., Cincinnati; University of Cincinnati College of Medicine, 1921; aged 69; died November 6; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A practicing physician of long standing in Cincinnati, Dr. Felter specialized in pediatrics. Surviving are his widow, a daughter and a sister.

A. Bruce Gill, M. D., Mount Dora, Fla.; University of Pennsylvania School of Medicine, 1905; aged 88; died November 8. Long time a practitioner in Pennsylvania before his retirement, Dr. Gill maintained close association with Muskingum College from which he graduated in 1896. His widow survives.

Macy Ginsburg, M. D., Canton; Jefferson Medical College of Philadelphia, 1921; aged 68; died November 17; member of the Ohio State Medical Association. A practicing physician of some 40 years standing in Canton, Dr. Ginsburg was associated with the Masonic Lodge, the Exchange Club and Temple Israel. Survivors include his widow, a daughter, a stepdaughter and two sons; also a brother.

Julien Shaw Jones, M. D., Lisbon; Western Reserve University School of Medicine, 1938; aged 58; died November 27; member of the Ohio State Medical Association and the American Medical Association. A general practitioner in Lisbon since 1944, Dr. Jones moved there from Cleveland. He was a 32nd Degree Mason and a member of the Kiwanis Club. Survivors include his widow, a daughter, a son and a sister.

R. P. McClain, M. D., Cincinnati; Howard University College of Medicine, 1913; aged 75; died on or about Oct. 31. Out of public life for some years because of ill health, Dr. McClain was formerly active in civic and political affairs of his area. A practicing physician in Cincinnati for some 40 years, he was at one time a prominent leader in the Negro community.

Girard E. Robinson, M. D., Bellpoint; College of Physicians and Surgeons of Baltimore, 1903; aged 90; died November 13; member of the Ohio State Medical Association, and an active participant in



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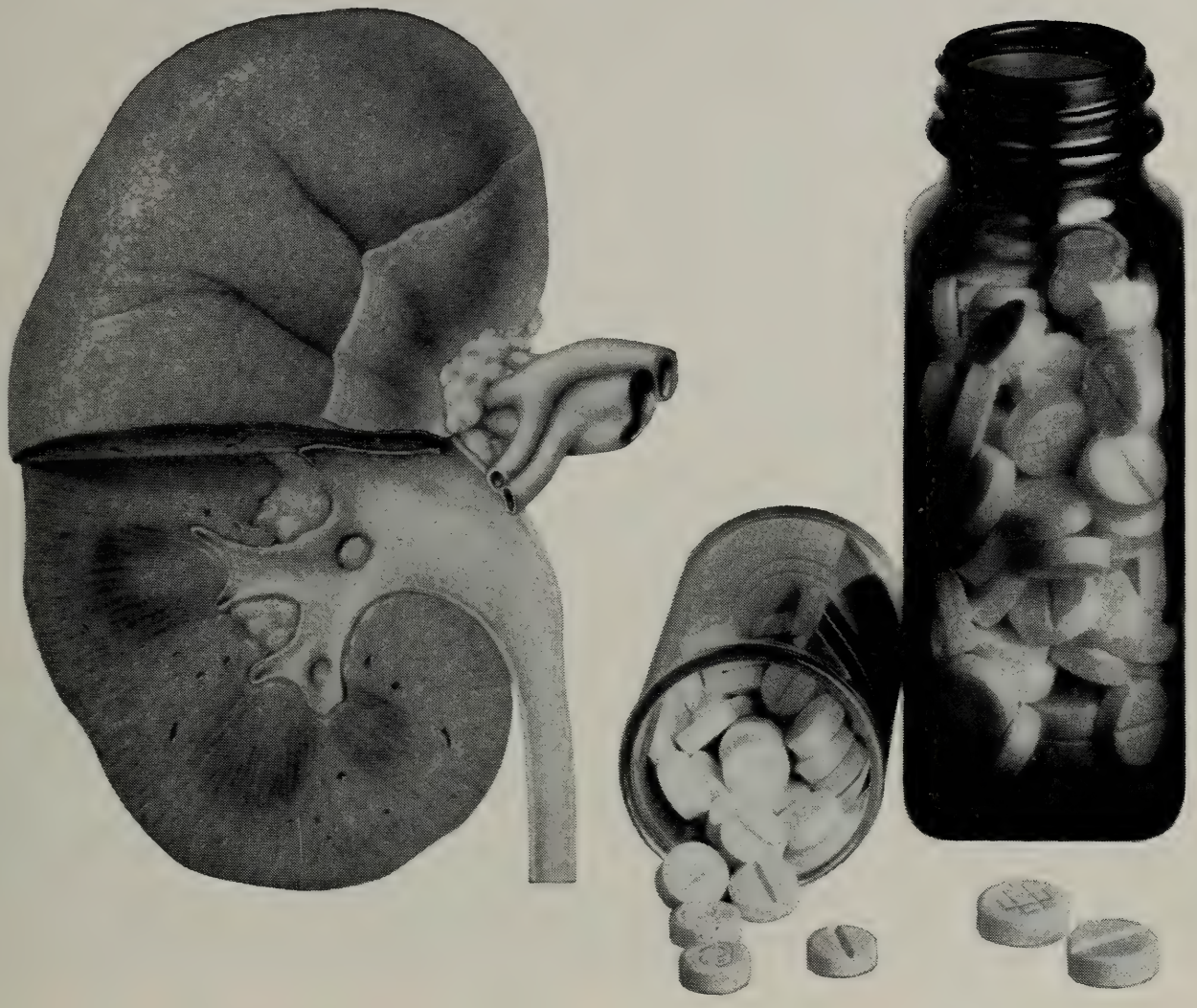
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For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

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medical organization work on the county and state levels. A physician in the Delaware County area for virtually all of his career, Dr. Robinson continued to practice until about a year ago. He was a past-president of the Delaware County Medical Society, served on numerous committees of the society, and was a delegate to the OSMA House of Delegates. He also served on numerous committees of the State Association. Civic activities included some 20 years service on the County Board of Education and many years on the County Board of Health, of which he was a former president. He was a veteran of World War I and a member of the Knights of Pythias. Among survivors are two daughters and a son, Dr. John Robinson, of Buffalo, N. Y.

Amos Boyer Sherk, M. D., Campbell; Starling Medical College, Columbus, 1903; aged 84; died November 8; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician for more than 60 years, Dr. Sherk served nearly all of his professional career in the Campbell and Youngstown area. A member of the Methodist Church, he is survived by his widow and a sister.

John Walter Smith, M. D., Grand Rapids, Ohio; McGill University Faculty of Medicine, 1923; aged 68; died December 1; member of the Ohio State Medical Association and the American Medical Association. A native of Canada, Dr. Smith took his internship in Toledo and began practicing in the Wood County community in the 1920's. He was a veteran of both World Wars. Affiliations included memberships in several Masonic orders and the Presbyterian Church. Surviving are his widow, a niece who grew up in the home, and a sister.

Harold Henry Teitelbaum, M. D., Youngstown; Royal College of Physicians and Surgeons, Scotland, 1938; aged 57; died November 21; member of the American College of Chest Physicians and American Thoracic Society. A resident of Youngstown since about 1950, Dr. Teitelbaum was superintendent of the Mahoning Tuberculosis Sanitarium. His widow, a son and a daughter survive.

Frank George Wellman, M. D., Cincinnati; University of Cincinnati College of Medicine, 1919; aged 71; died November 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Wellman's practice in Cincinnati extended over a period of more than 45 years. He was a member of the Catholic Church. Surviving are his widow, three daughters, a sister and three brothers.

William Andrew Welsh, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1919; aged 74; died November 27; member of the Ohio State Medical Association and former member of the American Medical Association. Dr. Welsh's practice in Youngstown extended over some 46 years and included appointments as county home physician and county jail physician. He was a member of the Tippecanoe Country Club, the Presbyterian Church and the Elks Lodge. Surviving are his widow and a son.

Prescription Drug Manufacturers Name Association President

The Board of Directors of the Pharmaceutical Manufacturers Association announced the election of C. Joseph Stetler, of Washington, as president of the association, which represents 140 companies, producers of 90 per cent of the nation's prescription drugs.

A native of Ohio, Mr. Stetler is an attorney and former general counsel for the American Medical Association, and former director of the AMA's Legal and Socio-Economic Division.

Mr. Stetler succeeds Dr. Austin Smith, who held the first full-time office as president of the organization for about six years. Dr. Smith resigned to accept an appointment by the Board of Directors of Parke, Davis & Company, Detroit, to its vice-chairmanship and to membership of its Executive Committee.

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Activities of County Societies . . .

First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

BUTLER

Dr. Brady Randolph, chairman of the society's program committee, discussed school athletic programs at the October meeting of the Butler County Medical Society.

It was emphasized that Butler County has a physician present at every high school football game and a follow-up system in case the designated physician cannot be present.

HAMILTON

"The Physician as a Defendant" was the theme of discussion for the December 14 meeting of the Academy of Medicine of Cincinnati in the headquarters building. A mock trial was presented with members of the Cincinnati Bar Association and Academy members participating.

The meeting was a testimonial to the 50-year physicians and awards were presented as part of the program.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

CLARK

Dr. Henry M. Tardif was elected president of the Clark County Medical Society during the annual election of officers (November 15) in Hotel Shawnee. Dr. Tardif has been a general practitioner in Springfield since 1949. He succeeds Dr. John F. Riesser, retiring president of the society.

Other officers include Dr. Harold B. Elliott, president-elect; Dr. Robert O. Cunningham, secretary; Dr. Wesley E. Knaup, treasurer; Dr. Ernest H. Winterhoff, delegate to the Ohio State Medical Association, and Dr. Charles J. Townsend, alternate delegate to the Ohio State Medical Association.

Dr. C. Lowell Edwards, of Oak Ridge, Tenn., former member of the U. S. Public Health Service and now chief clinician for the Medical Division of the Oak Ridge Institute of Nuclear Studies, was featured as speaker of the evening.

Speaking on "Medical Uses of Radioactive Isotopes — Past, Present and Future," Dr. Edwards told the history of the new field of nuclear medicine and outlined some of the practical uses of radioactive isotopes in medicine. — *Springfield Daily News.*

MIAMI

Dr. Aaron Weinstein, assistant director of the Department of Radiology at the Veterans Administration Hospital, Cincinnati, and assistant professor at the University of Cincinnati College of Medicine, was program speaker for the November meeting of the Miami County Medical Society. His subject was "Hands — Reflectors of Disease." The dinner meeting was held at the Piqua Country Club.

MONTGOMERY

Dr. Edward R. Annis, Past-President of the AMA, was speaker for the November 12 meeting of the Montgomery County Medical Society in Dayton. Following a reception and dinner for physicians, their wives and guests, Dr. Annis spoke on the topic, "The Untold Story of Medicine."

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Lima and area students in the 11th grade of high school were invited to participate in "Medical-Health Career Days" on November 13 in St. Rita's and in

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Lima Memorial Hospitals. Events at both hospitals were sponsored by the Academy of Medicine of Lima and Allen County.

Students were oriented in careers of medicine, nursing, x-ray technology, practical nursing, physical therapy, medical technology, pharmacy, dentistry, dietetics, social work, speech therapy and occupational therapy. Representatives of these various fields were invited to participate in the program. Also parents, school counselors and school officials were invited to attend.

HARDIN

The Hardin County Medical Society had its November meeting at San Antonio Hospital, where Dr. Ivan J. Podobnikar discussed the various patient disorders related to the field of the psychiatrist. A psychiatrist in Lancaster, Dr. Podobnikar is associated also with the Mental Health League in Bellefontaine.

SENECA

Officers for 1966 were elected at a dinner-meeting of the Seneca County Medical Association Tuesday (Nov. 17) evening at the New Riverview Inn, Tiffin. Dr. Olgierd Garlo, Tiffin, was elected as president and Dr. Lowell K. Good, Fostoria, as vice-president. Dr. Leonard Gaydos, Tiffin, was elected as secretary-treasurer. — *Fremont News Messenger.*

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The Inter-Hospital Postgraduate Lecture Series was given November 11 and 12 by Dr. Ephraim Roseman, professor of neurology, University of Louisville Medical School. The "Neurological Symposia," included discussions of cerebral localization, strokes, epilepsy, meningitis, spinal cord diseases and dystrophies.

* * *

The Academy of Medicine of Toledo and Lucas County program for December contained the following features:

December 2 — Specialties Section — Joint meeting of Toledo OB-Gyn Society and Pediatric Society; panel discussion on "Erythroblastosis."

December 3 — General Section — Annual committee reports by all committee chairmen; report of nominating committee.

Also joint meeting of Toledo Bar Association with the Academy.

December 10 —Joint meeting of dentists and physicians. Part of the program was the showing of a film entitled, "Safety First, Second and Third."

* * *

For its 64th annual meeting, the Academy will hear a talk by Dr. Nicholas P. Dallis, former Toledo psychiatrist, who now devotes his full time to authorship of three cartoon strips, Rex Morgan, M. D., Judge Parker, and Apartment 3-G. His topic will be "The Mode of American Life."

The January 12 meeting will be in the Commodore Perry Hotel. A 6:00 p. m. social hour will be followed by a banquet and the program.

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

CUYAHOGA

A joint meeting of the Academy of Medicine of Cleveland and the Cleveland Bar Association was held on December 7 in the Manger Hotel. A social hour and dinner preceded the program.

Speaker for the occasion was Dick Schapp, editor, writer and syndicated columnist, whose topic was "Image Makers and Image Shakers."

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

The Mahoning County Medical Society conducted its annual diabetes detection drive during the week of November 14-20.

(see page 75)

TRUMBULL

The regular meeting of the Trumbull County Medical Society was held on November 17 at the Trumbull Country Club. The meeting followed a social hour and dinner.

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Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

The annual Specialty Society Day of the Academy of Medicine of Columbus and Franklin County was held on November 15 in the Sheraton-Columbus Motor Hotel in downtown Columbus.

Speaker for the occasion was Dr. Peter H. Knapp, Boston Mass., whose topic was "Psychophysiologic Medicine: Science and Skill."

Co-sponsors of the program were the Columbus OB-Gyn Society, Central Ohio Academy of General Practice and the Neuropsychiatric Society of Central Ohio.

The annual Christmas Banquet of the Academy was held at the Sheraton-Columbus Motor Hotel on December 4. Following a social hour, dinner and entertainment by the Woman's Auxiliary Glee Club, members and guests enjoyed an evening of dancing.

* * *

The Academy of Medicine of Columbus and Franklin County held its annual Christmas Banquet on December 4 at the Sheraton-Columbus Motor Hotel.

Entertainment was furnished by the Herb Germain Trio and by the Woman's Auxiliary Chorus.

Seven physicians were presented the 50-Year Award of the Ohio State Medical Association for a half century of service in the medical profession.

Present to receive the awards were Dr. Henry A. Minthorne, Dr. Rivington H. Fisher, and Dr. William N. Taylor. Not present at the meeting, but authorized to receive the awards also are Dr. Joseph M. Dunn, Dr. Philip J. Reel, Dr. William A. Millhon, and Dr. James H. Warren.

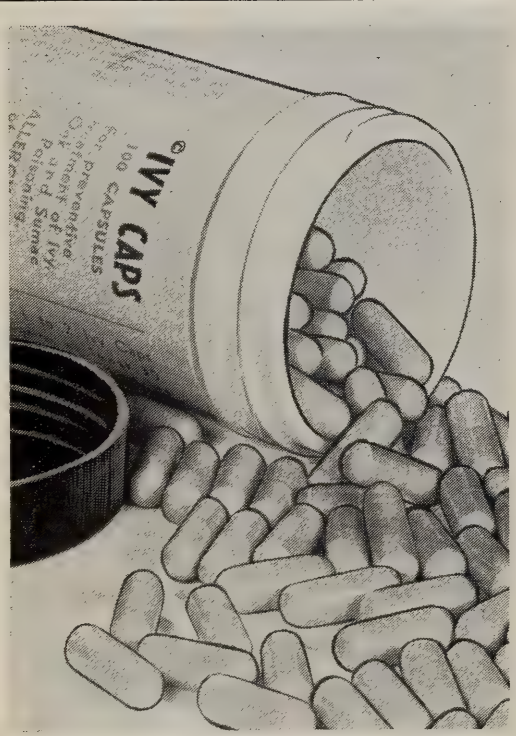
* * *

KNOX

The Knox County Medical Society was a co-sponsor of twelfth grade students, parents, young adult teachers, youth workers, clergy, etc., in Mt. Vernon. Dr. and Mrs. John C. Willke, Cincinnati, presented the program on the subject, "Sex Education for Children and Its Application to Dating and Marriage." The Willkes have given numerous lectures on that field of education and have written a book entitled *The Wonder of Sex.*

Dr. Albert B. Sabin, Cincinnati, was named winner of the Albert Lasker Medical Research Award for his clinical research and development of the live-virus oral polio vaccine. The award carries with it a $10,000 honorarium.

The 1966 American Industrial Health Conference will be held April 25-28 in Detroit, Michigan, with headquarters at the Sheraton Cadillac Hotel and meetings in Cobo Hall, it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses.



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Mahoning County Health Care Symposium



This is one of several panel groups which participated in the Mahoning County Community Health Care Symposium, this one discussing "Availability of Medical Facilities. From left, are: Luther Ihle, administrative assistant at South Side Hospital; Kenneth W. Wisowaty, Department of Hospitals and Medical Services of the AMA; J. W. Tandatnick, M. D., and B. C. Berg, M. D., panel moderators; and William B. Esson, administrator of South Side Hospital.

Youngstown Program Puts Meaning Into Community Health Week

The press in Youngstown and in the surrounding area gave excellent support to the "Community Health Care Symposium" sponsored by the Mahoning County Medical Society as a Community Health Week Service.

The public meeting held in the Mural Room Building was well attended, and those present heard discussions by several panel groups representing the various organizations and facilities involved in community health.

Dr. John J. McDonough, president of the Medical Society, opened the meeting with a brief address.

Featured Luncheon speaker was Dr. J. Everett McClenahan, medical director of McKeesport Hospital, McKeesport, Pa. His topic was "Hospital Utilization."

In addition to persons named in the above picture, the following panel groups were represented to give their views:

Panel on "Problems of Medical Personnel" — S. V. Squicquero, M. D., moderator; Gene R. Payton, Youngstown Hospital Association; Sister M. Charlene, director of nursing service at St. Elizabeth Hospital; Miss Rae Glass, chief technologist in the Department of Laboratories of Youngstown Hospital Association.

Panel on "Problems of Rising Health Care Costs" — C. W. Stertzbach, M. D., moderator; Donald Surridge, D. O.; Mr. Wisowaty; Sister M. Consolata, administrator of St. Elizabeth Hospital; Mr. Esson; Raymond Fine, Esq., Secretary of the Board of Youngstown Osteopathic Hospital; Ralph (Bob) White, Eastern Ohio Pharmaceutical Association.

Panel on "Role of the Third Party" — Jack Schreiber, M. D., moderator; John B. Morgan, Jr., executive vice-president, Associated Hospital Service; Ned F. Parish, assistant executive vice-president, National Association of Blue Shield Plans; Arthur Hess, director of the Health Insurance Division of the Department of Health, Education and Welfare; Louis Orsini, director of the Health Insurance Council of America; Richard Shoemaker, associate director of the Department of Social Security, AFL-CIO; Russell Roth, M. D., chairman of the AMA Council on Medical Services.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during November. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

Allen

Hector A. Buch, Lima
Peter W. Reed, Lima
Dixie Lee Soo, Lima
Liang Yee Soo, Lima

Cuyahoga

Josephine Shou-Chen Chu, North Olmsted
Gilbert Erlechman, Cleveland
Michael J. Eymontt, Cleveland
Richard J. Harsa, Chagrin Falls
William K. Littman, Cleveland
Ratko Ljuboja, Cleveland
Mary E. Mohr, Cleveland
Thomas P. O'Malley, North Olmsted
Dennis H. Smith, Cleveland
Robert D. Zaas, Cleveland

Franklin

Robert A. Gill, Jr., Columbus
Donald E. Hoffman, Columbus
Albert L. Kunz, Columbus
Jerry G. Liepack, Columbus
Brant W. Tedrow, Groveport
Ronald C. Van Buren, Columbus

Jefferson

Jack A. Scott, Steubenville

Lorain

Emanuel Onlayao, Elyria

Lucas

Thomas T. Bakondy, Toledo
Nicholas R. DeFronzo, Toledo

Montgomery

Sergio J. Alejandrino, Dayton
Robert E. Caporal, Dayton
John E. Carroll, Jr., Dayton
Richard J. Dobies, Dayton
Calvin L. Edwards, Dayton
Harley M. Ellman, Dayton
George R. Fronista, Dayton
Harry Fronista, Dayton
Philip C. Hughes, Dayton
Douglas P. Longenecker, Englewood
Hsien-ming Meng, Dayton
Hugh D. Pittman, Dayton
John R. Scharf, Dayton
Douglas A. Shanahan, Jr., Dayton
James F. Sheridan, Dayton
James K. Skahen, Dayton
Robert A. Washing, Dayton

Summit

Glenn E. East, Akron
Jose M. Melian, Akron

Trumbull

Michael J. Casale, Warren
William Moskalik, Girard
John O. Vlad, Warren

Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

* * *

How important is the patent system to the prevailing health care picture? Here are a few examples. In 48 years, Russia's government-owned pharmaceutical industry has not developed a single new and important drug. In 24 years, thanks in part to patent protection, the American pharmaceutical industry has come up with at least 75 new drug entities. Credit (and a considerable amount is due) must go to a competitive industry that thrives in a competitive economy — motivated by the rewards and contributions to knowledge that the nation's patent system has always guaranteed. — Editorial in *GP* (32:5), November 1965.

* * *

Few, if any, new drugs or inventions have been commercially developed in countries which do not offer proper patent protection to the inventor. Of the new drugs introduced in the United States from 1941 to 1964, 369 came from the United States, 44 from Switzerland, 33 from Germany, and 28 from the United Kingdom. Equally significant is that 90 per cent of the 369 new drugs originating in the United States came from company laboratories. —Editorial in *Michigan Medicine,* (64:766), October 1965.

* * *

I maintain that an experienced observer can tell whether a drug puts a patient to sleep, relieves pain, stops a cough, relieves an itch, lifts a depression or improves motility in arthritis without placebos and double-blind controls. Reciprocally, I have seen smart, young, relatively inexperienced investigators completely miss the obvious with their sophisticated technology. There is a place for sound, simple, clinical observation and I hope general practitioners will insist on having their data considered along with the other. I have an idea that they will be right as often as their younger, instrumented, double-blind brethren. — Theodore K. Klumpp, M. D., in *GP,* (32:203), November 1965.

An estimated two million Americans have diabetes and don't know it, the Health Insurance Institute reported. Another two million know they have diabetes and are being treated.

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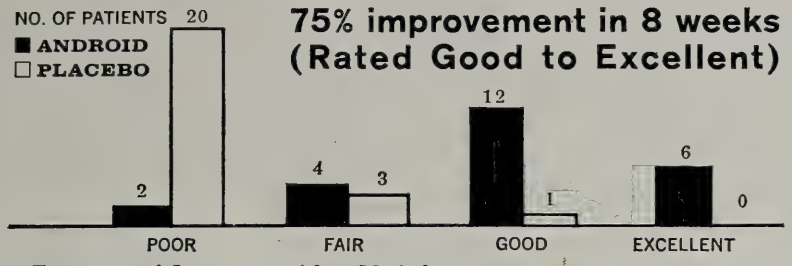
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* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence*. A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.

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Thyroid Ext. (¼ gr.).....15 mg.
Thiamine HCl.....25 mg.
Ascorbic Acid (Vit. C).....250 mg.
Glutamic Acid.....100 mg.
Pyridoxine HCl.....5 mg.
Niacinamide.....75 mg.
Calcium Pantothenate.....10 mg.
Vitamin B-12.....2.5 mcg.
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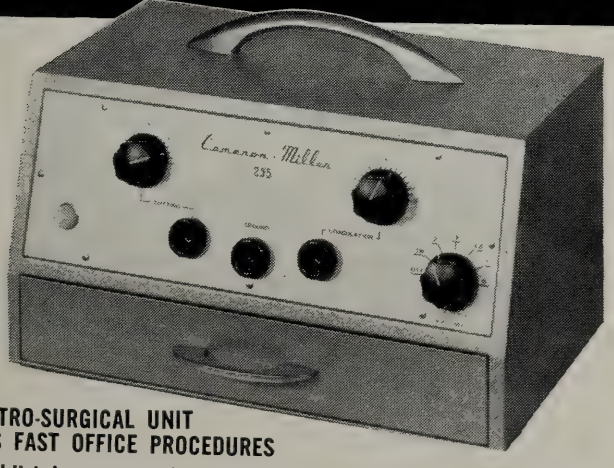
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Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth

"RING out the old, ring in the new." The old year — passed into the mists of Time. The new year — young, lusty, full of hope and promise. Dare we hope that as doctors' wives we can in some small measure make it a more meaningful, purposeful year? Yes, we can hope. And we can do. **If we really want to make the effort . . .** We are not miracle workers and we are limited in our endeavors. But no matter the limit, we still have an amazing area in which to soar, to grow, to accomplish. The national Auxiliary says it so beautifully: "Let the helping hands of the doctor's wife reflect and enrich his dedicated service."

New Year's resolutions may or may not be to your liking. But it is well to reflect that by "resolving" to do thus and so, we are conscious of our shortcomings and are at least making an effort to do something about them. I have, from time to time, heard certain doctors' wives comment "My husband is doing all that is necessary for the medical profession. I see no need to involve myself." How wrong! How wrong! There is a need and a place for every doctor's wife to help in serving her community. And she can do it no more effectively than through her auxiliary. I should like to suggest this resolution for all doctors' wives: "I resolve that I shall consider the Woman's Auxiliary to my husband's County Medical Society the most important organization to which I can belong, and that, pridefully, I shall help to further its work in the never-ending fight for good health."

Two State Chairmen Speak

Mrs. Virgil C. Hart, Health Careers chairman, recommends a brand new exhibit particularly of interest to high school and college students who have an eye toward a medical career. She describes "A Career in Medicine" as a colorful, well lighted display, easily assembled, featuring a literature rack for pamphlets which are shipped with the exhibit. An excellent feature for Health Careers Day. The exhibit may be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, and the only cost is that of transportation.

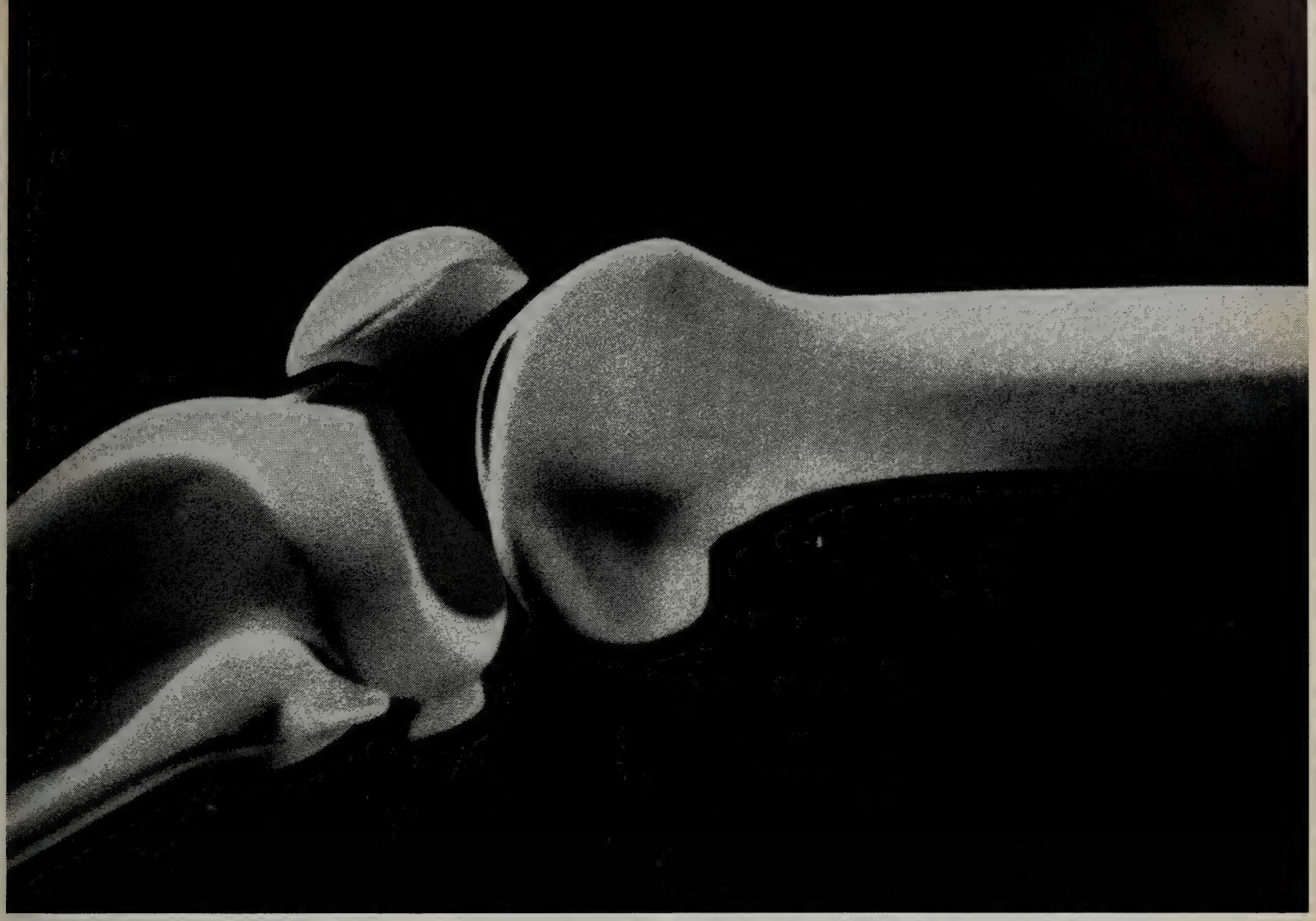
Mrs. Joseph Moran, Jr., Mental Health chairman, speaks of the appalling percentage of mental illness among teenagers and points out that local auxiliaries have the challenge of finding out what the needs of the individual communities are and then organizing their forces to be of all possible assistance. She mentions "Mirror to the Mind" — a very fine educational series that consists of 13 records made by Doctors Annis and Menninger concerning mental health. Ideally, they can be used by local radio stations as a public service with one record being broadcast each week for 13 consecutive weeks. These records are available from the Radio and Communications Committee of the American Medical Association.

"Milestones to Maturity" are also effectively used in many areas as an educational program for the young people. They consist of eight letters for senior high school students and are designed to educate the youth in relation to problems of maturing. One thing more — an effective Suicide Prevention Program has been planned and executed by a former national Mental Health chairman. Mrs. Moran points out that this program can be established in any community regardless of size, but it is necessary to have the approval of the local County Medical Society. If you are interested in further details, contact Mrs. Moran at 2251 Townley Road, Toledo 43606.

Around the State

There's a very newly installed president at the **Clark County** auxiliary — Mrs. A. T. Anton, and a newly appointed vice-president, Mrs. S. J. Glueck. The group furnishes refreshments to the cerebral palsy clinic and the Children's Home. It also sponsors a nurse's scholarship. Honorary members of the auxiliary were honored recently at a luncheon at Valley View Inn. They included Mrs. C. Evans, Mrs. W. B. Patton, Mrs. M. S. Collins, Mrs. W. B. Quinn, Mrs. A. Richard Kent and Mrs. H. B. Martin. At its November meeting, the auxiliary met for a dessert luncheon at the home of Mrs. Edwin Roberts. The program featured the work of members who participate in community activities. On the coming agenda is the big project — the bazaar, proceeds of which go to AMA-ERF.

A sale of handicraft items made by members of the **Columbiana Auxiliary** netted over one hundred dollars for the County School for Retarded Children. The sale was held in conjunction with the regular November meeting at the Salem Golf Club. Mrs. Wade A. Bacon, president, introduced the two honored guests — Mrs. Herbert Van Epps, state president, and Mrs. James Wychgel, state president-elect. Mrs. Harold Martsolf, teacher at the Elkton School,



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Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

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presented an interesting account of the fine work being done for retarded children.

The October meeting of the Columbiana group featured a wig display by the Trans-World Wig Company of Cleveland at the home of Mrs. R. J. Starbuck. Beauticians from the Kaercher Beauty Salon of Salem modeled the wigs. Mrs. R. J. Bonistalli, president-elect, conducted the business session in the absence of the president. Refreshments were served by the hostess Mrs. Starbuck, assisted by Mrs. J. R. Milligan, Mrs. G. A. Roose, and Mrs. Liesel Falkenstein.

"Holiday in Rome"

A "Holiday in Rome" was simulated at the Roof Garden of the Hotel Sheraton-Gibson in Cincinnati when **the Hamilton County** group held its December dinner dance for the benefit of the philanthropic fund. The annual Holiday Ball has provided nursing scholarships each year since 1948. A Roman piazza was created for the occasion. A splashing fountain and weathered colonnade were accented by massive urns holding magnolia greens. The traditional attraction of tourists on Roman holiday — the tossing of coins into the fountain — was one of the evening's diversions. The collection was subsequently turned over to "The Neediest Kids of All" Christmas Fund. Mrs. John L. Thinnes was general chairman of the black-tie affair. Strolling musicians in bright costume moved among the tables during the dinner hour playing Italian folk songs. For each table, Mrs. William P. Jennings, Mrs. Roy H. Kile and their assistants fashioned ceramic fountains of antique green spattered with gold. These were centered on gold filigree mats. Since doctors are on call even in the ballroom, Mrs. Samuel Bauer enlisted a group of hostesses who delivered telephone messages to the physicians. These women were identified by gold coins worn as pendants.

Mrs. Eugene P. Fromm served as invitations chairman; Mrs. E. A. Kindel, Jr., as reservations chairman and Mrs. William H. Kroovand as ball treasurer. Name tags were designed by Mrs. Robert E. Johnstone. Mrs. Robert Matuska was chairman of "ospitalita" for the evening. Mrs. John B. Toepfer is president of the Hamilton doctors' wives.

The **Hancock auxiliary** met recently at the Findlay Country Club and viewed the film "A Different Drum" which features projects of AMA-ERF. A question and answer session followed, headed by Mrs. Thomas Darnall. Mrs. Robert Brown and Mrs. James Miller were hostesses. Mrs. A. P. Carneiro, president of the **Jefferson County** group, entertained the members at a luncheon at the Steubenville Country Club.

Mrs. C. L. Johnson spoke on "The Various Phases of Medicare" at the November meeting of the **Hardin County** women at San Antonio Hospital. During the business session conducted by Mrs. Calvin Jackson, president, plans were made for the annual Mistletoe Ball in December. Mrs. Max Schnitker, program chairman of the **Lucas County** auxiliary, arranged the guest-day tea at which Mrs. Alexander Miller spoke on Project Hope. Mrs. Miller is the wife of a Cleveland orthopedic surgeon who has served as a volunteer doctor on Hope and who at the present time, is in South Viet Nam as a volunteer in an undertaking administered by Project Hope and the Agency for International Development.

On and On They Go!

The **Mahoning County** auxiliary had a tremendously effective picture spread in the rotogravure section of *The Youngstown Vindicator.* It all had to do with its group of volunteer workers in conjunction with Diabetes Week, AMA-ERF, drug samples for World Relief and the tuberculosis Christmas Seal campaign. The picture layout was certainly publicity at its very best. The **Miami auxiliary** held a tea recently for junior and senior high school girls interested in nursing careers.

A unique program was presented at **Scioto County's** 25th anniversary dinner party at Holiday Inn — a presentation on and a demonstration of the remarkable laser beam. The doctors of the Scioto County Medical Society were the honored guests. Kenneth Bartter of Marion, public relations manager for the General Telephone Company of Ohio, described the laser beam as a light beam with virtually magic-like qualities. The telephone executive presented a broad, non-technical concept of how it works in the fields of communication, medicine, industry,

---

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Vice-Presidents: 1. Mrs. A. L. Kefauver
4421 Aldrich Pl., Columbus 43214

2. Mrs. M. W. Sloan, II
415 Towerview Rd., Dayton 45429

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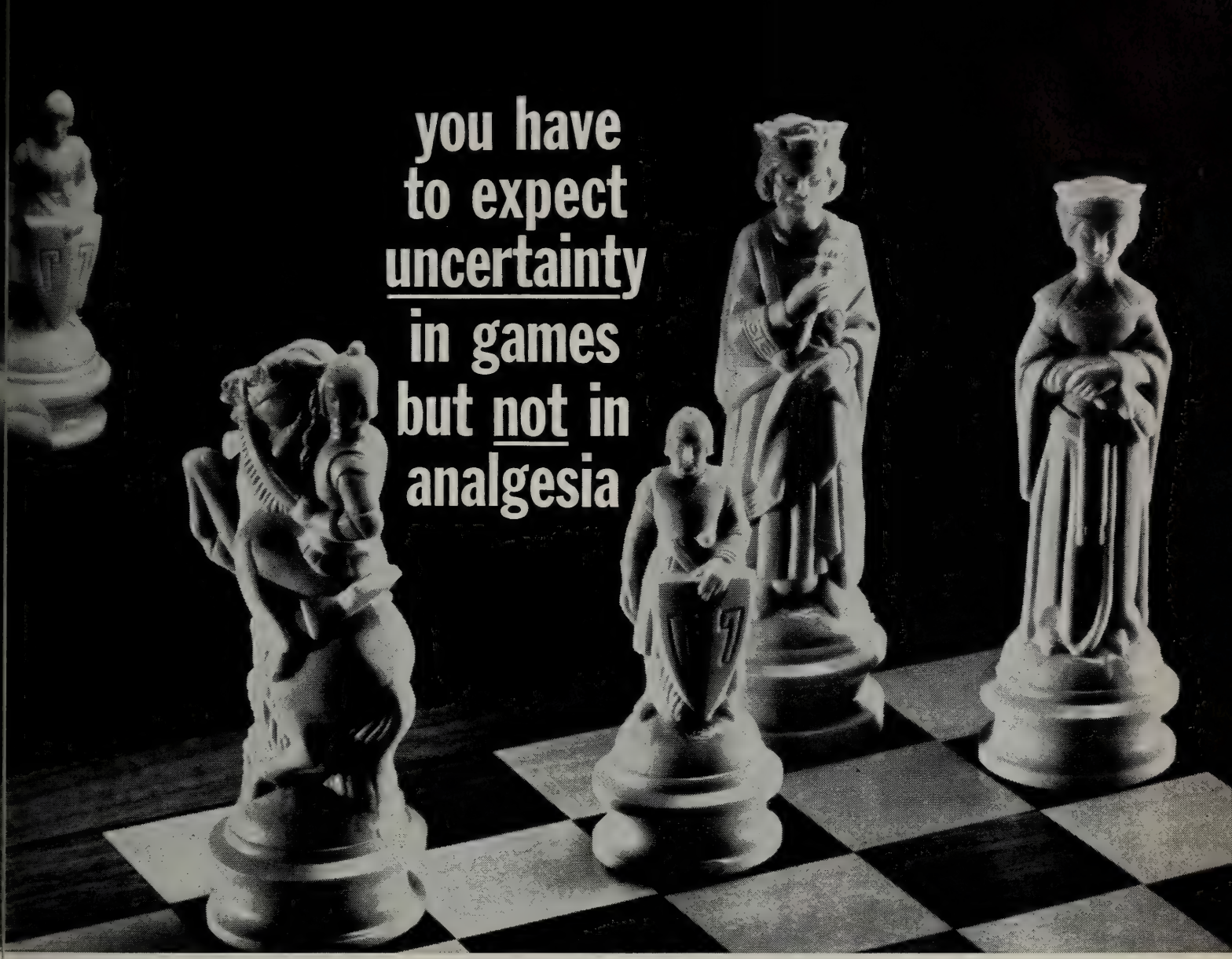
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science and the military and then demonstrated its amazing capability.

Mrs. Alden Oakes, Scioto president, presided at the festivities. A special exhibit of scrapbooks, photographs, posters and all manner of educational presentation highlighted the projects of the group's 25 years of existence.

The December meeting featured the annual Christmas party traditionally held at the home of Dr. and Mrs. Clyde M. Fitch in the form of a dessert luncheon. Members brought toys for needy children. There were also a bake sale and a book sale to swell the treasury of the Ways & Means Committee.

A panel of Clergy and physicians discussed the film "The One Who Heals," following its showing in November when the **Sandusky County** auxiliary hosted the Ministerial Association, their wives, Catholic clergy and physicians at the Nurses' Home. The group was welcomed by Mrs. Harold Keiser, president. Discussing the film and answering questions were the Rev. James Konrad, president of the Ministerial Association, Father John Thomas, Dr. Richard Wilson and Dr. Robert Gedert. Mrs. Howard Yost headed the refreshment committee.

Medical Missionary

The **Stark County** auxiliary heard a distinguished physician talk about an unusual experience at its November luncheon at the Arrowhead Country Club. Dr. Igor Nikishin, Canton surgeon, discussed his several weeks this summer in Honduras as a medical missionary. He took part in the "Amigos de Honduras" project initiated by the River Oaks Baptist Church at Houston, Texas. Some 300 persons, many of them teen-agers, formed their own "Health Corps" and assisted by about 25 members of the AM-DOC (American Doctors) organization undertook a medical treatment program for some two million Hondurans. During his rough truck trip to the city of Santa Rosa de Copan where he was stationed at a primitive hospital, Dr. Nikishin passed through several villages. Of these he recalled: "We made our way, bump by bump in complete silence, between gray-white walls of mud mixed with straw, with holes for doors and windows — these filled by men, women and naked children, all with immensely protruding stomachs. The villagers drank from a nearby river where pigs and dogs splashed, or straight from the gutter along the street." The hospital at which Dr. Nikishin served was founded in 1917 and gets support from the government. Patients who are able pay 12½ cents on their first day, the doctor said. Treatment is free to the penniless. "Patients are placed two to a bed in the adult wards," he related, "and up to four children share each bed in their section. Among other ailments, they are treated for jaguar and machete wounds, burns, fractures, malnutrition, anemia, parasites and infections."

Happy New Year!

Happy New Year on behalf of your State Board. There is a favorite quotation of mine (author unknown) that seems to fit this occasion — "Thine own wish, wish we thee."

The Ohio State University College of Medicine has received a grant of $26,457 for planning a university-wide interdisciplinary program in mental retardation. The planning will be a joint effort of representatives from the College of Education, School of Social Work and the College of Medicine. Dr. Lloyd R. Evans, assistant dean of the College of Medicine, will direct the project.

This year's winner of the Gorgas Medal, presented annually by the Association of Military Surgeons of the U. S. is Lt. Colonel Edward L. Buescher, a 1948 graduate of the University of Cincinnati College of Medicine, and now stationed at the Walter Reed Army Medical Center. The award consists of a medal, scroll and honorarium established by Wyeth Laboratories.



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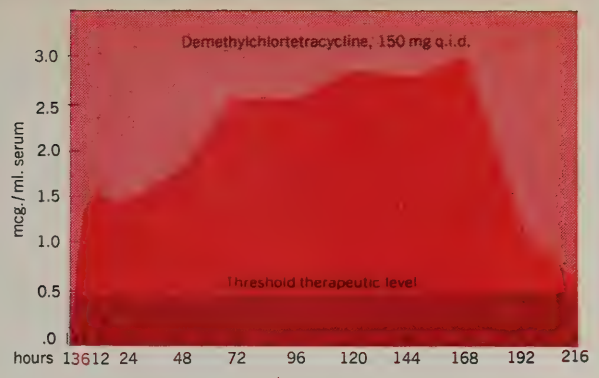




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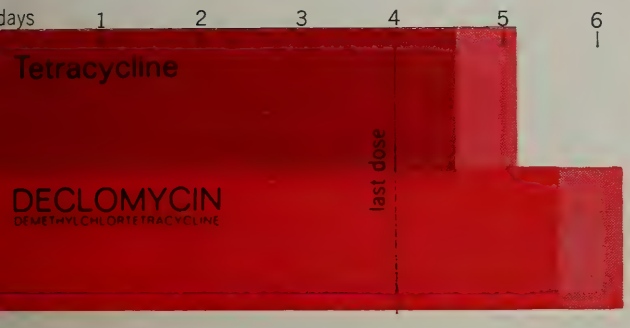
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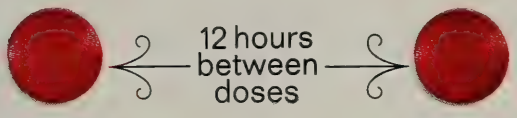
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Ohio's Vital Statistics ...

Interesting Information Is Included in the Annual Statistical Report of the Ohio Department of Health

THE 1964 Annual Report on "Vital Statistics" being a summary of information compiled by the Ohio Department of Health's Division of Vital Statistics was recently released by Dr. Emmett W. Arnold, Department director.

Population

In 1964, the July 1 estimate of population for Ohio was 10,425,175, an increase of 158,971 or 1.5 per cent over the 10,266,204 estimate for July 1, 1963. An excess of births over deaths (net natural increase) accounted for 115,871 or approximately 73 per cent of this increase.

The 1964 mid-year population estimates for the State, counties and cities were used to compute rates based on population shown in this report.

Live Births

There were 209,480 live children born to mothers residing in Ohio during 1964, 3,103 fewer than were born in 1963. This is the seventh consecutive year that the actual number of births has been less than the preceding year's total. The live birth rate was 20.1 per 1,000 population in 1964, slightly less than the 20.7 rate in 1963 and the lowest in the State since the rate of 19.2 in 1945.

During 1964, there were 108,467 male and 102,013 female resident births in Ohio. The sex ratio of 1,063 males for every 1,000 females was slightly higher than the sex ratio of 1,058 males to 1,000 females in 1963.

White births totaled 187,096 in 1964. This is a decrease of 1,871 from the 189,967 white births in 1963. Nonwhite births decreased 432 in number from the previous year. The number of nonwhite births for 1963 and 1964 were 22,616 and 22,384, respectively. The white birth rate decreased from 20.2 in 1963 to 19.6 per 1,000 white population in 1964. The nonwhite rates showed a very slight decrease from 26.8 in 1963 to 26.2 per 1,000 nonwhite population in 1964. The nonwhite birth rate is 34 per cent higher than the white rate for the year 1964.

Natural Increase

For the calendar year 1964, the natural increase in the population (excess of births over deaths) was 112,925 giving a total resident birth rate which exceeded the death rate by 10.9 per 1,000 population. For the white population, the rate of increase was 10.4 per 1,000 and for the nonwhite population, 16.5 per 1,000.

In 1964, there were 205,188 single and 4,292 plural resident live births in Ohio; 4,220 were born in twin deliveries and 72 were born in higher order deliveries. The plurality rate of 20.5 per 1,000 live births was similar to the rate of 20.0 in 1963.

Illegitimate live births increased from 11,561 in 1963 to 12,775 in 1964. The illegitimacy ratio of 61.0 per 1,000 live births represents a 12 per cent increase over the ratio of 54.4 in 1963.

Over 25 per cent of the total number of live births to resident mothers of Ohio were first born children, and about 22 per cent were second births.

Women between the ages of 20-29 years were responsible for over 60 per cent of the total number of live births. Mothers in the age group 20-24 years represented 36 per cent of this figure, while 26 per cent is accounted for by those in the age group 25-29 years. There were 289 births to mothers under 15 years of age and 215 births to mothers 45 years of age and over.

Premature Births

Premature births, those with a birth weight of 2,500 grams or less, totaled 16,514 or 7.9 per cent of all Ohio resident live births in 1964. The premature birth rate of 78.8 per 1,000 live births, showed no appreciable difference from the 1963 premature rate of 78.4.

In 1964, the number of resident fetal deaths reported were 2,953 — 30 less than were reported in Ohio during the year 1963. The fetal death rate of 14.1 per 1,000 live births was the same for both of the years 1963 and 1964.

Infant Deaths

Ohio's resident infant deaths decreased from 4,938 in 1963 to 4,614 in 1964. The infant death rate per 1,000 live births also showed a decline from 23.2 in 1963 to 22.0 in 1964. The nonwhite infant death rate of 35.6 per 1,000 live births was 74.5 per cent higher than the white death rate of 20.4 per 1,000 live births.

Deaths peculiar to early infancy accounted for 2,971 or 64.4 per cent of the 4,614 deaths under one

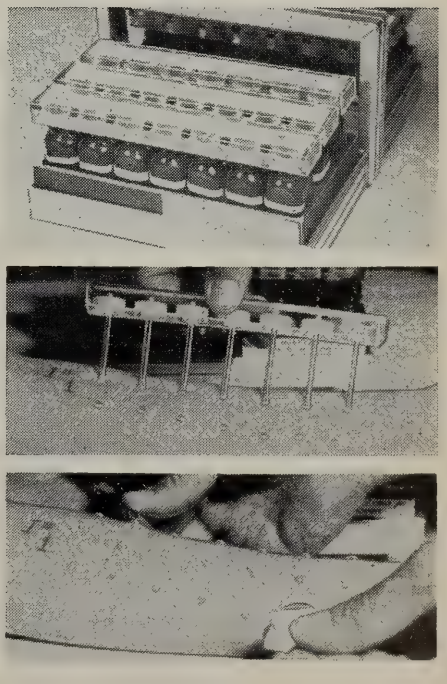


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year of age. Congenital malformations were the cause of 759 infant deaths. There were 494 deaths due to diseases of the respiratory system, 105 due to accidents, and 93 due to disease of the digestive system.

Neonatal deaths (those occurring within the first 27 days) accounted for 3,560 or 77.1 per cent of all infant deaths for the year 1964 in Ohio. In 1963, 3,775 or 76.4 per cent of the infant deaths were reported as neonatal deaths.

Maternal Deaths

In Ohio, the 58 maternal deaths in 1964 resulted in a resident maternal death rate of 2.8 per 10,000 live births, slightly lower than the 63 deaths with the rate of 3.0 per 10,000 live births in 1963.

Deaths — All Causes

There were 96,555 deaths among residents of Ohio in 1964, a decrease of 412 over the 1963 total of 97,967. The crude death rate of 9.3 per 1,000 population in 1964 differed slightly from the 1963 rate of 9.5.

Marriages and Divorces

The year 1964 showed an increase of 1,304 marriages over the previous year. There were 74,979 marriages performed in Ohio in 1964 representing a marriage rate of 7.2 per 1,000 population.

In Ohio, there were 25,053 divorces and annulments reported for the year 1964, an increase of 5.6 per cent over the 23,731 granted in 1963.

Life Insurance Research Fund Helps Projects in Ohio

Several Ohio research projects have been promoted by grants from the Life Insurance Medical Research Fund, according to the annual report marking the 20th anniversary of the fund. Among Ohio projects mentioned in the report are the following:

Metabolism of Catecholamines in Septic Shock, Thomas E. Gaffney, University of Cincinnati College of Medicine, $18,700.

Mechanisms of Action of Vasoactive Peptides, Especially Angiotensin, Dr. Philip A. Khairallah, Cleveland Clinic Foundation, $24,200.

Factors Influencing Cardiac Output in Man, Dr. James V. Warren, Ohio State University College of Medicine, $11,000.

Intracardiac Valve Prostheses, Dr. Frederick S. Cross, St. Luke's Hospital, Cleveland, $7,700.

Biosynthesis of Cholesterol Precursors, Harry Rudney, Western Reserve University School of Medicine, $20,240.

Dr. G. W. Ryall, Shaker Heights, recently presented a paper on "The Classification of Headaches and Their Relation to Allergy," at the International Congress of Otolaryngology in Tokyo, Japan. The stopover in Japan was made while Dr. and Mrs. Ryall were on a trip around the world.

Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

* * *

A new drug may not be shipped across state borders for administration to a human until the sponsor of the drug (who may be the investigator) has filed a request for exemption for such use with the FDA. He must describe and identify the source of the drug and its manufacturer; he must describe previous animal studies with the drug to show that it is reasonably safe to initiate human studies; he must give evidence of his professional qualifications and his facilities for investigation.

Finally, the investigator must certify that he will obtain consent from the persons receiving the drug except where this is not feasible or, in the investigator's best judgment, is contrary to the best interest of the subjects. The sponsor must also make progress reports at appropriate intervals, not exceeding a period of one year. He must promptly report any adverse effect which is reasonably regarded as due to the drug. He must maintain records for a period of two years after the drug has been approved or disapproved, or after his investigations have been discontinued. — Joseph F. Sadusk, Jr., M. D. to Association of Military Surgeons, November 17, 1965.

* * *

Since there is no such thing as an absolutely safe drug, nor is there a drug that will prove effective in every patient in which it is used, the best we can achieve is a balance; that is, where potential benefit outweighs potential risk. It should be stressed that the benefit-risk ratio is not a constant. The scientist can afford a larger risk in a severe disease for which there is no completely effective therapy, for example, in leukemia, than he can in a relatively benign disorder. — FDA Commissioner George P. Larrick in *Emory University Quarterly,* (21:95), Summer 1965.

* * *

Drugs of the future will be better tolerated by patients and will act with greater specificity. In the field of radiology, new agents will facilitate x-ray diagnostic procedures of the brain. Space medicine research promises to bring a beneficial fall-out of drugs for use in vestibular malfunctions, protection from harmful radiation, and reduction in fatigue. Other exotic areas of research may produce compounds that offer protection from extreme heat, and others from extreme cold. A pill that would repel insects is another possibility. The future of drug research was never brighter. The results will add to man's longevity, and will reduce the discomfort, suffering, and disability of disease. — Austin Smith, M. D., in *Emory University Quarterly,* (21:141), Summer 1965.

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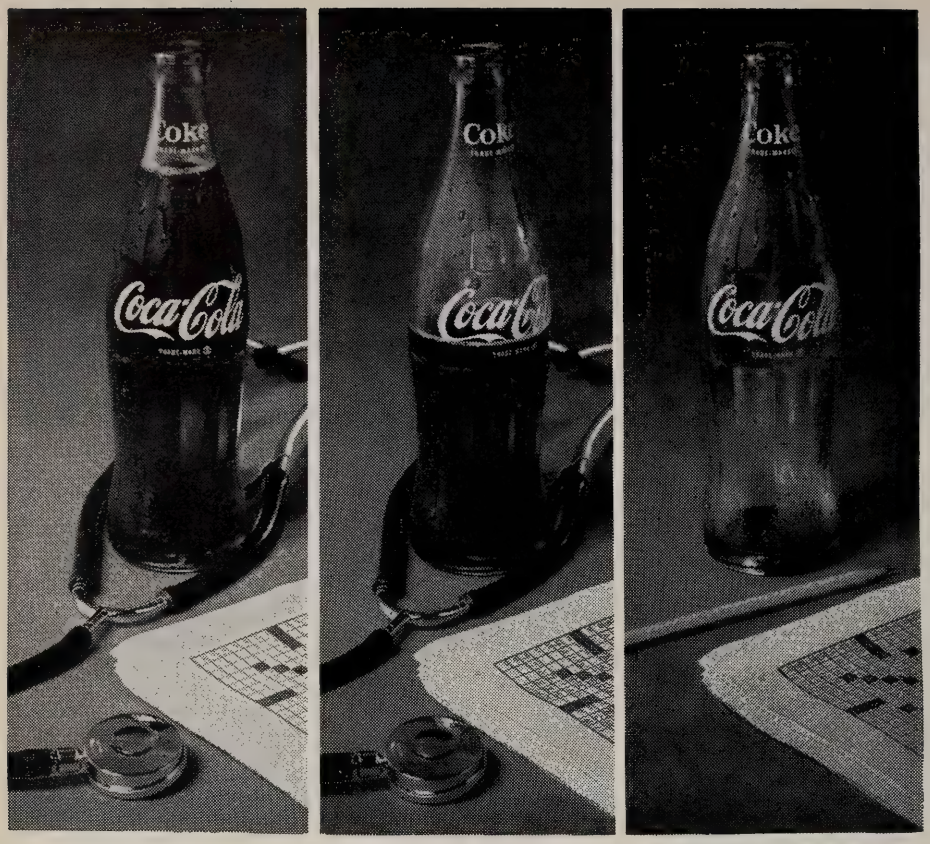
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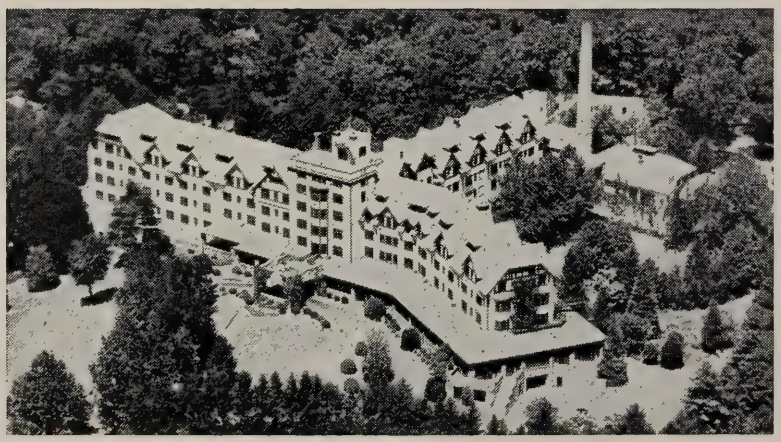


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Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild. *Before prescribing, see SK&F product Prescribing Information. Smith Kline & French Laboratories, Philadelphia*



"Sponsored Funds" Putting Strain On Medical School Finances

The total dollar amount of medical school expenditures from funds for regular operations (expenditures for sponsored programs excluded) reached a new high in 1964, according to a report of the Division of Operational Studies of the Association of American Medical Colleges.

Expenditures for regular operations of a medical school are derived from funds that are under the control of the medical school and serve as the primary support of education and service functions of the school. The source of these funds is mainly from tuition and fees, state and city appropriations and subsidies, unrestricted gifts and grants, endowment income, transfers from general university funds, and income from the service activities of the school.

Expenditures from funds for regular operating programs have shown steady annual increases but in spite of this fact medical school deans and university administrative officers are finding it progressively more difficult to meet the increasing costs of education, service, and research activities.

The marked growth in sponsored funds, devoted mainly to research and research training, has also placed an increased financial burden on the medical schools because sponsored funds (restricted gifts and grants) rarely, if ever, completely support programs for which the funds are designated.

However, benefit to the regular operating programs is derived from the utilization of personnel and facilities that are supported by sponsored program expenditures.

The funds available to medical schools for the support of their regular operating programs are considered as "hard cash" income and constitute the primary source of support for growth and development.

In the five year period from 1959 to 1964 the annual level of expenditures from funds for regular operating programs has increased from $175 million to $286 million. In 1959, individual school expenditures ranged from $648,000 to $5,956,000. In 1964, school expenditures ranged from $939,000 to $8,811,736.

The number of schools that have expenditures of more than $3 million from funds for regular operating programs has grown from 15 in 1959 to 44 in 1964.

Even with the increases already achieved there remain several inadequately financed schools. Furthermore, the fulfillment of the predicted increased manpower requirements will demand significantly greater expenditures.

Dr. Harman A. Shecket, Cleveland, was elected a trustee of the American College of Gastroenterology, at the fall meeting of the organization in Bal Harbour, Florida.

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meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

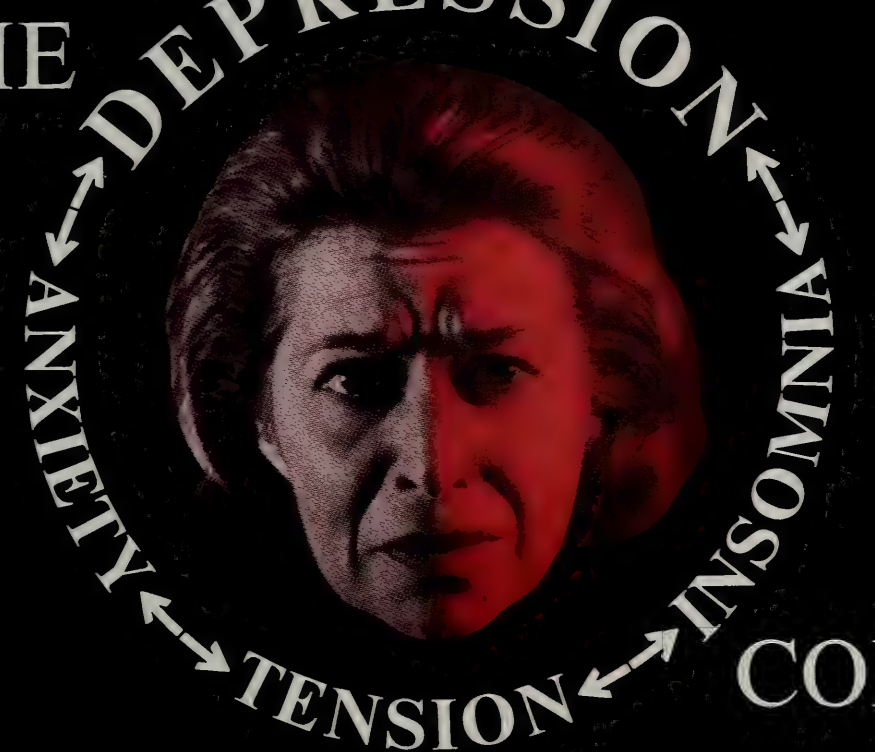
Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

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even when complicated by anxiety, tension, insomnia, agitation or rumination.

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American Medical Journalism . . .

The World Is Looking to the U. S. for Medical Leadership As Indicated by Widespread Demand for AMA Publications

UNTIL about a generation ago, the United States imported more medical knowledge than it exported. In popular fancy, the American doctor was seen learning at the feet of a bearded European professor.

Today it is different. U. S. medical science and medical education have come of age and the United States is a net exporter of medical theory and technique. In medicine as in many other fields the world looks to the United States for leadership. Communist nations pay us the compliment of pirating from American medical publications.

American medical journals are an important means of disseminating up-to-the-minute medical knowledge throughout the world. They supplement the other major vehicle for exportation of medical knowledge: medical education. Thousand of foreign doctors have been educated in American medical schools and hospital postgraduate programs since the end of World War II and most of them probably stay in contact with American medicine through medical journals.

123 Countries

The weekly *Journal of the American Medical Association,* is distributed to more than 8,000 paid foreign subscribers in 123 countries. The 10 monthly AMA specialty journals (dermatology, surgery, internal medicine, diseases of children, environmental health, general psychiatry, neurology, ophthalmology, otolaryngology, and pathology) go to more than 16,000 paid foreign subscribers. Nearly 2,000 copies of the *AMA News* go to selected foreign subscribers, and *Today's Health,* the AMA medical publication for laymen, has a paid foreign circulation of nearly 10,000.

Thus, the publications of the AMA alone have a paid foreign circulation of nearly 40,000. (Total domestic and foreign Journal circulation is 212,504 per week; total specialty journal circulation is 222,307 per month.)

To a British physician on Harley Street, *JAMA* and the specialty journals may be necessary checkpoints in a week of "keeping up with the journals." British physicians, like American, probably read 10 to 20 medical publications regularly. To a physician practicing in Southeast Asia, though, a single copy of *JAMA* at the local hospital may be a most valued contact with current medical thought.

Some underdeveloped nations receive only one or two copies of JAMA through paid subscriptions, and these often go to a hospital; but the AMA Department of International Health estimates that nearly every English-speaking doctor and medical technician having access to the "hospital copy" makes an attempt to read every issue. The estimate is made on the basis of conversations with foreign doctors visiting the U. S., and with U. S. physicians returning from service in underdeveloped nations.

The Ohio State Medical Journal Is Circulated Abroad

The Ohio State Medical Journal, although it is slanted primarily for physicians in Ohio, has a substantial circulation outside of the continental limits of the United States.

In addition to copies going to Ohioans in the Armed Forces overseas, *The Journal* is mailed each month to the following places: Virgin Islands (2), Switzerland, Sweden, South Africa (2), Poland, the Philippines, Iran, the Netherlands (2), Mexico (2), Lebanon, Indonesia, India (3), Hawaii (2), Italy, West Germany, Finland, England (3), Chile, the Canal Zone, Canada (7), Brazil and Australia.

This makes 38 copies of *The Ohio State Medical Journal* going outside of the continental limits of the U. S. each month, or 456 copies a year. If other states are sending their medical journals overseas in the same proportion, the total may have a considerable impact on medical thinking and medical training abroad.

Multiple Readership

Nearly every major medical school and medical library in the world also gets at least one copy of *JAMA* for teaching and reference. Information volunteered to the AMA Department of International Health by foreign physicians indicates that a single library copy of *JAMA* may go through the hands of 40 or more readers.

Through *JAMA,* the AMA specialty journals, and other professional publications physicians in Iron



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Vitamin B_6 (Pyridoxine HCl	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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Curtain countries keep in close touch with American medical trends.

A number of Communist nations, including isolationist Albania, Bulgaria, the Soviet Union, and Mainland China, receive from one to a dozen copies of *JAMA* weekly. Most of the copies go to medical schools, where, according to the AMA Circulation and Records Department, they often are duplicated for wider distribution. Although the published material in *JAMA* is protected by copyright, the Soviet Union and some other Communist states do not recognize copyright regulations.

As an indication of the extent to which the Soviet Union duplicates *JAMA*, only six paid-subscription copies are sent to the USSR but nearly every Russian physician who visits the United States confides that he is a regular *JAMA* reader.

Medical Missionaries

Hundreds of American medical missionaries in foreign lands receive *JAMA* and other AMA publications free of charge. The AMA furnishes the publications as a means of permitting these dedicated doctors to stay abreast of medical developments and remain in contact with main currents of American medicine, despite their isolation from medical centers. *JAMA* circulation to some countries — the Congo and New Guinea, for example — is all or nearly all of this non-paid type.

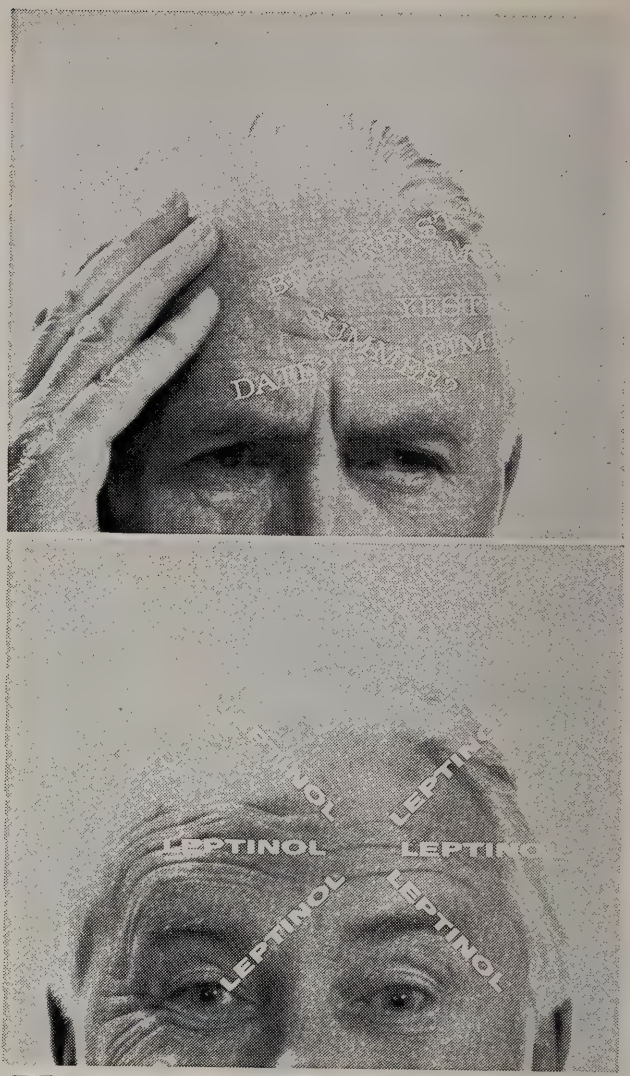
Some examples of *JAMA* paid-subscription circulation throughout the world: 1,135 copies go to Canada. More than 200 of these are to Montreal, and hundreds more to Toronto, Ottawa, and other major centers of Canadian population. In the vast northern areas of Canada a number of doctors are served by a hospital "single copy": one such example is the single copy of *JAMA* sent to Whitehorse General Hospital, Whitehorse, Yukon Territory. Paid-subscription circulation of all AMA publications in Canada is 12,045. (Canada has about 22,600 physicians, according to World Health Organization statistics.)

The four *JAMA* copies going to Afghanistan are received by two U. S. Peace Corps physicians, a UNICEF Public Institute in the Ministry of Health, and an American medical team operating on funds from a private U. S. organization.

A single copy to Ocean Island in the Central Pacific is received by the British Phosphate Commission. Four Bulgarian medical institutions get five paid-subscription copies.

Circulation in Viet-Nam (six paid-subscription copies and many more free copies) is divided among hospitals, individual Vietnamese doctors, medical missions, American physicians serving in Project Viet-Nam, and the American Embassy in Saigon.

The 10 foreign nations with highest *JAMA* circulation are Canada, 1,135; Italy, 777; Japan, 671; England, 346; India, 338; Holland, 318; Mexico, 298; France, 275; West Germany, 260; Sweden, 250.



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Leptinol is a useful medication that deters senile mental deterioration by stimulating the cerebral vasomotor and respiratory centers . . . increasing pulmonary ventilation and the supply of blood and oxygen to the brain.

Non-addicting Leptinol also is valuable in long-term treatment, since patients do not establish a tolerance.

Each LEPTINOL bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE: one or two tablets, 3 times daily. Leptinol produces such a sense of well-being, patients should be cautioned not to exceed recommended dose which offers maximum effectiveness.

Side Effects:—overdosage may produce tremor, convulsions or respiratory paralysis.

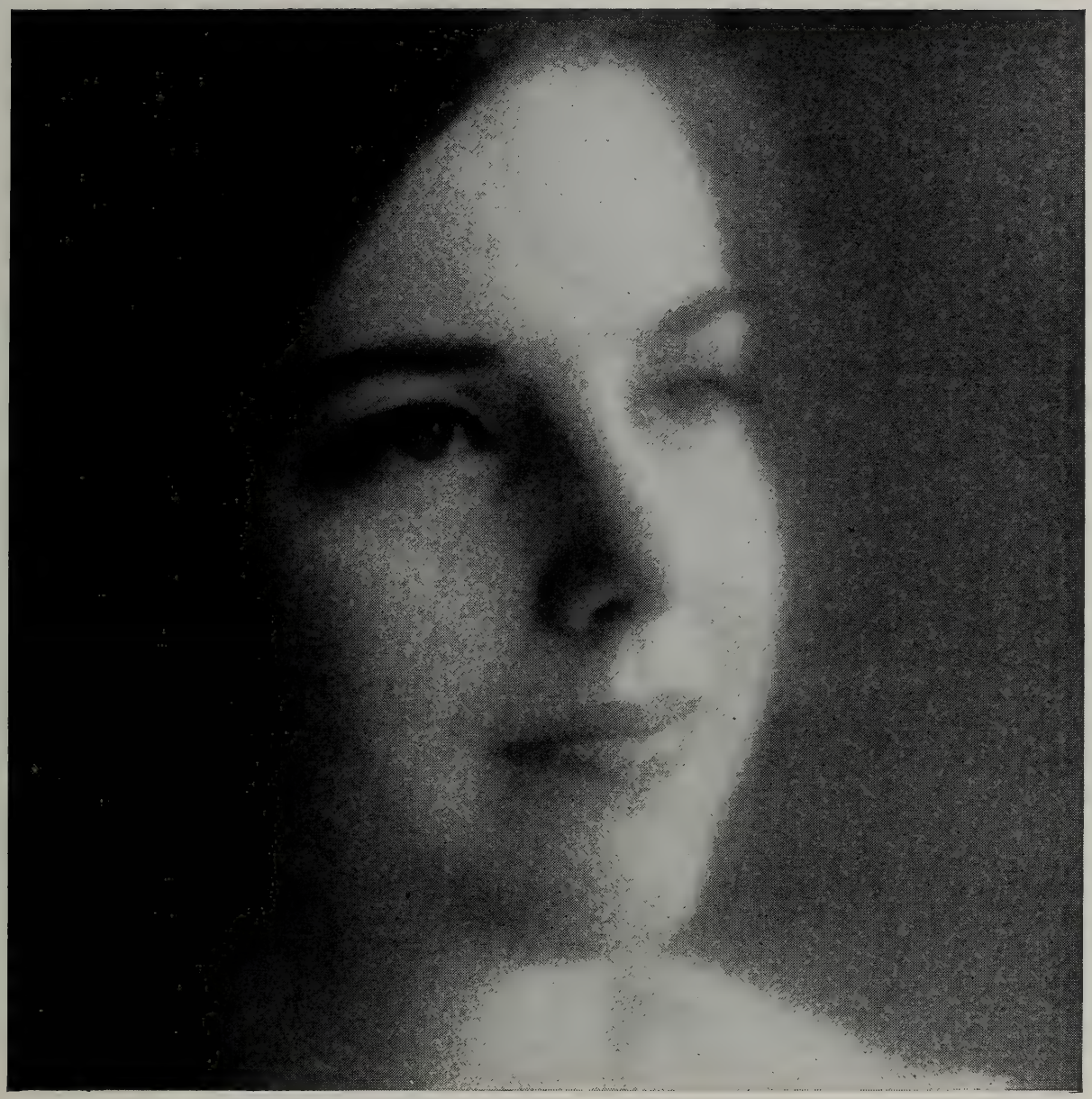
Caution should be taken when treating patients with a low convulsive threshold.

Write for detailed literature and starter Leptinol doses.

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Three of 54 Ohio Senior Physicians Honored in 1965



Shown at the Stark County Medical Society meeting, these physicians display the 50-Year gold button and Certificate of Distinction presented in behalf of the Ohio State Medical Association. From left, are Dr. Howard S. Myers, of Massillon; Dr. Loren L. Frick, North Canton; and Dr. C. J. Schirack, of Canton.

Ohio Honors 54 Senior Physicians With Certificates of Distinction

Several years ago The Council of the Ohio State Medical Association authorized the issuance of 50-Year Awards to physicians in good standing in the profession who had served with distinction as members of the profession over a period of a half century or more. In 1965, Certificates of Distinction and gold buttons were issued to 54 doctors who had become eligible for the awards in that year.

In most instances the awards were presented by Councilors of respective Districts at meeting of County Medical Societies.

The certificate reads as follows: "Certificate of Distinction — 50 Years in the practice of medicine. The Ohio State Medical Association is honored to have the privilege of awarding this Certificate of Distinction to (doctor named) in recognition of his devotion to his patients, his contributions to the health and wealth of the public, and his allegiance to the principles of the medical profession as a practitioner of the art and science of Medicine for Fifty or more years." Certificates are signed by the OSMA President and Executive Secretary.

The three physicians pictured above were honored at the annual meeting of the Stark County Medical Society. (See write-up under Mahoning County in the Activities of County Medical Societies for more details about them and the presentation.)

Ohio Workmen's Compensation Actuarial Report on Funds

THE Ohio Bureau of Workmen's Compensation during a recent two-year period paid out more than $19 million for medical services to injured workers, according to actuarial reports of the agency.

During the calendar year 1963, the Bureau paid out for medical services to injured Ohio workers $9,175,391.97, including a small amount for dental services.

Other payments during that year, exclusive of compensation payments, included the following amounts: For hospital care and nursing, $15,411,-937.74; for funeral expenses, $158,995.55; for miscellaneous costs, $72,010.52; a total, including medical services, of $24,818,335.78.

These amounts include payments covering treatment of injured private and public employees as well as similar costs for occupational disease claims.

The number of claims filed for 1963 was 305,-780; or 0.25 per cent less than in the previous year. Medical-only claims numbered 232,286, or 76.0 per cent of claims filed.

The average amount paid out for medical-only claims increased from $22.67 in 1962 to $25.51 in 1963.

Figures for 1964

For the calendar year 1964, the Bureau paid out for medical services to injured workers $9,820,389.16, including some dental services. Other payments that year included the following amounts: For hospital care and nursing, $16,210,449.72; for funeral expenses, $141,655.53; for miscellaneous costs, $95,-739.07; a total including medical services of $26,-268,233.48.

The number of claims filed for 1964 was 346,114, or 13 per cent more than in 1963. Medical-only claims numbered 270,901, or 78.3 per cent of claims filed.

The average amount paid out for medical-only claims increased from the $25.51 figure of 1963 to $28.36 in 1964.

Drug Company Takes Steps To Keep Damaged Products Off Market

Smith Kline & French Laboratories has arranged with the nation's principal salvage companies for the return of Smith Kline & French products damaged by fire or other mishap or acquired by salvage companies as a result of bankruptcies.

A spokesman for the company said this policy has been adopted so that possibly damaged SK&F products will not be distributed and also to help keep SK&F products from unintentionally getting into unauthorized drug distribution channels.

What To Write For

Directory of Health Facilities Planning Agencies. The 196-page directory lists existing planning agencies by location with information about each. Single copy available without cost to physicians and certain organizations. Address, Department of Hospitals and Medical Facilities, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

* * *

Characteristics of Residents in Institutions for the Aged and Chronically Ill, Statistics on age, sex, color, length of stay, and selected health characteristics, based on data collected April-June, 1963. Public Health Service Publication No. 1000 — Series 12 — No. 2. Order from Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402; price 40 cents.

* * *

Aging Center in Sinai Hospital. One of a series entitled "Portraits in Community Health," being an illustrated description of the services at Sinai Hospital of Baltimore. Public Health Service Publication No. 1344-2, for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 — Price 20 cents.

* * *

Immunization Information for International Travel, revised June, 1965. Order from the Superintendent of Documents, Government Printing Office, Washington, D. C., 20402; 35 cents a copy.

* * *

Quackery's Gray Area, a discussion of mail order treatment of epilepsy. One of several pamphlets available from the Epilepsy Foundation, 1419 H Street, N. W., Washington, D. C. 20005.

* * *

Planning Kitchens for Handicapped Homemakers. An 82-page monograph based on extensive research in this field. Order from Publications Unit, Institute of Physical Medicine and Rehabilitation, New York University Medical Center, 400 East 34th Street, New York, N. Y. 10016.

* * *

Cancer of the Prostate. This is the ninth in a series of ten U. S. Public Health Service pamphlets on cancer of different body sites, prepared for the public. Other pamphlets in the series deal with cancer of the breast, uterus, skin, bone, lung, stomach, larynx, colon and rectum. Single copies of "Cancer of the Prostate" (PHS Publication No. 1352) are available without charge from the Public Health Service, Washington, D. C. 20201. Quantities may be ordered from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402, at five cents a copy or $2.75 per hundred.

Levi Rogers

Frontier Doctor, Pastor and Statesman

PHILLIPS F. GREENE, M. D.*

PART I

ON APRIL 4, 1815, Doctor Levi Rogers died suddenly in his 47th year. More than 60 years later, the Clermont County historian, H. J. Bancroft wrote of him, "In his death the spark of life departed from one of the brightest of the medical profession that ever lived in Ohio. Hardly a household existed in the county where Levi Rogers was not known in terms of kind affection and loving memory, . . . being a noted physician of skill, culture and extensive practice."[1] As one reviews the record of his life this eulogy appears wholly deserved. He was indeed a most remarkable and lovable man, one of the ablest and most versatile of his day.

Levi Rogers was born about 1769, probably in South Jersey near Philadelphia. As a young man he was a circuit riding preacher of the Methodist Episcopal Church. His name first appears in the general minutes for 1792; "remaining on trial. Appointed to the Bethel N. J. circuit." He was 23 years old. The general minutes for 1793 state: "received into full connection. Appointed to the Bristol, Pa. circuit." In 1794 he was placed in charge of the Burlington, New Jersey circuit and given an assistant preacher to aid him. In 1795 he is listed as "located," which, in his case, meant he had resigned as a preacher to take up other work.

In 1795 he married Anna George, the only child of John and Sarah George of Gloucester, New Jersey. About this time he began the study of medicine. He and his bride may have lived with her parents. By 1797 he was attending the medical lectures at the University of Pennsylvania. His name appears in the class list of Dr. Benjamin Rush for 1797-1798. He also studied under Drs. Shippen, Wise, Wister, and Barton. He seems to have taken but the one year. He is listed in the official records of the University of Pennsylvania Medical School among the nongraduates. In 1798 he began the practice of medicine on his own in Galaway Township, Gloucester County, N. J., not far from the present Atlantic City.

His father-in-law's illness in 1797 and death the winter of 1800-1801 probably influenced this move, for he had intended a second year at the University which would have led to an M. D. degree. Levi Rogers was designated the executor of John George's will. It was probated February 12, 1801. He and his wife inherited the George farm of 152 acres.

While young Dr. Rogers was building up a practice of medicine he was also reading law and preaching too. His name appears in the official records for 1801 as a justice of the peace for Gloucester County. Levi Rogers seems to have gotten off to a good start in South Jersey and to have had every prospect of advancement.

However, his heart was set on moving to the new state of Ohio. On February 3, 1802 he sold the George farm for $1866.70. He and his wife had bought an adjoining acre in 1801 for $12. In 1804 they sold this for $20, and with this sale the name of Levi Rogers drops out of the Gloucester County records.

Moves to Clermont County, Ohio

Early in 1804 they moved to Williamsburg, the county seat of Clermont. On Feb. 14, 1804 Levi bought for $16 lot No. 460. This was a quarter acre standing at the top of the hill overlooking the valley of the East Fork of the Little Miami River. It was a heavily wooded area sloping to the south, including at its lower end a brook. About the middle of this lot I found a lovely little spring from which a rill ran down to the brook. This lot was about a quarter of a mile from the main settlement. What a beautiful spot for their new home! And they loved it dearly.

Levi built a house "made of rond-poles. The door was so low that one must stoop to pass through. The poles were covered with clapboards held in place by more poles on the outside. Floor it had none but Mother Earth. Light was obtained through greased paper stretched across 'chinks.' Heat was secured and cooking performed in a clay fireplace. Such, for a time, was the abode of that gentleman and scholar, Dr. Levi Rogers."[2]

He thus became the first resident physician of Williamsburg. Here he set up his office as a "doctor of physic and chirurgery," a lawyer and a minister of the gospel.

During the next two years he bought ten additional

*Dr. Greene, New Richmond, is a member of the staff, Brown County Hospital at Georgetown; Yale in China, emeritus Professor of Surgery.
Submitted February 3, 1965.

lots for which he paid a total of $185. Six of them were on the same block as his first purchase. The others were in the main settlement. The Williamsburg Chair Factory now stands on two of these lots. When in 1814 he sold all his Williamsburg property, he was paid $300, a gain of 68 per cent.

Government Positions

The contrast between the enforcement of law and order as he had known it in New Jersey and what he found in Ohio caused Levi to ponder what he, as a citizen of the new state, should undertake. The first need was bringing offenders to court. So in 1805 when he had been but a year in Clermont County, he stood for the office of sheriff and was elected. In 1807 he was re-elected for another two years. Realizing that the prosecution of cases after they had been brought to justice at the court left much to be desired, he stood for the office of prosecuting attorney, resigning as sheriff in August 1808 in order to run for this office. He was duly elected and became the prosecuting attorney the Spring Term of 1809, subsequently serving several terms.

Ohio State Senator

In 1811 he was elected senator from Clermont County to the Ohio General Assembly. The 1811-1812 Assembly was the Tenth and sat at Zanesville from December 2, 1811 to February 21, 1812. Levi Rogers arrived on December 10th, was duly sworn in and plunged into the work of the Senate with his usual vigor. The next day he was sent by the Senate with a message to the House that, "the Senate concurred in their bill urging the Governor to consider the defenseless situation of Ohio and to notify Congress." Sending a new member with a message was the customary procedure for officially introducing him to the other chamber. It was especially fitting that this was Rogers' first official assignment, for the "defenseless situation of Ohio" was one of Levi's chief concerns. He considered that war with Britain was imminent, that Ohio would be attacked from Canada, and that the Ohio Militia was "unorganized and unruly." Throughout his two years in the Senate he took a responsible part in all that related to the War of 1812.

In his first session he worked hard for a bill "to regulate the commissioning of officers for the Ohio Militia," and another "to regulate the discipline of the Militia." The first became deadlocked 12-12 and the second bill lost 11-12.

When the 11th session of the Ohio General Assembly met in Chillicothe (December 7, 1812 - February 9, 1813) Levi Rogers was a recognized leader in the war effort. On December 31st the Assembly appointed General Duncan McArthur of the House and Dr. Levi Rogers of the Senate to confer with Governor Meigs "on the problem of arms for the Ohio Militia." About this same time General McArthur moved in the House and Levi Rogers sponsored in the Senate "A memorial that we view with astonishment and regret the refusal of the Governments of Massachusetts and Connecticut to furnish financial and military support in the prosecution of the war, as asked by the President of the United States." The Senate vote was 13-13.

Rogers was chairman of a committee to "encourage volunteers for military service," chairman of another committee "to bring in a bill to increase the efficiency of the militia," and member of the committee of three "for devising additional taxes for the support of the war."

Finally, Dr. Rogers offered his services as an Army Surgeon to the Federal Government. His friend Gen. Duncan McArthur recommended him to the Department of War, and Congress confirmed his appointment as Surgeon of the 19th Infantry U. S. Army on January 28, 1813. Rogers did not receive his official notice of this appointment until March 4th, 1813.

Ohio's Permanent Seat of Government

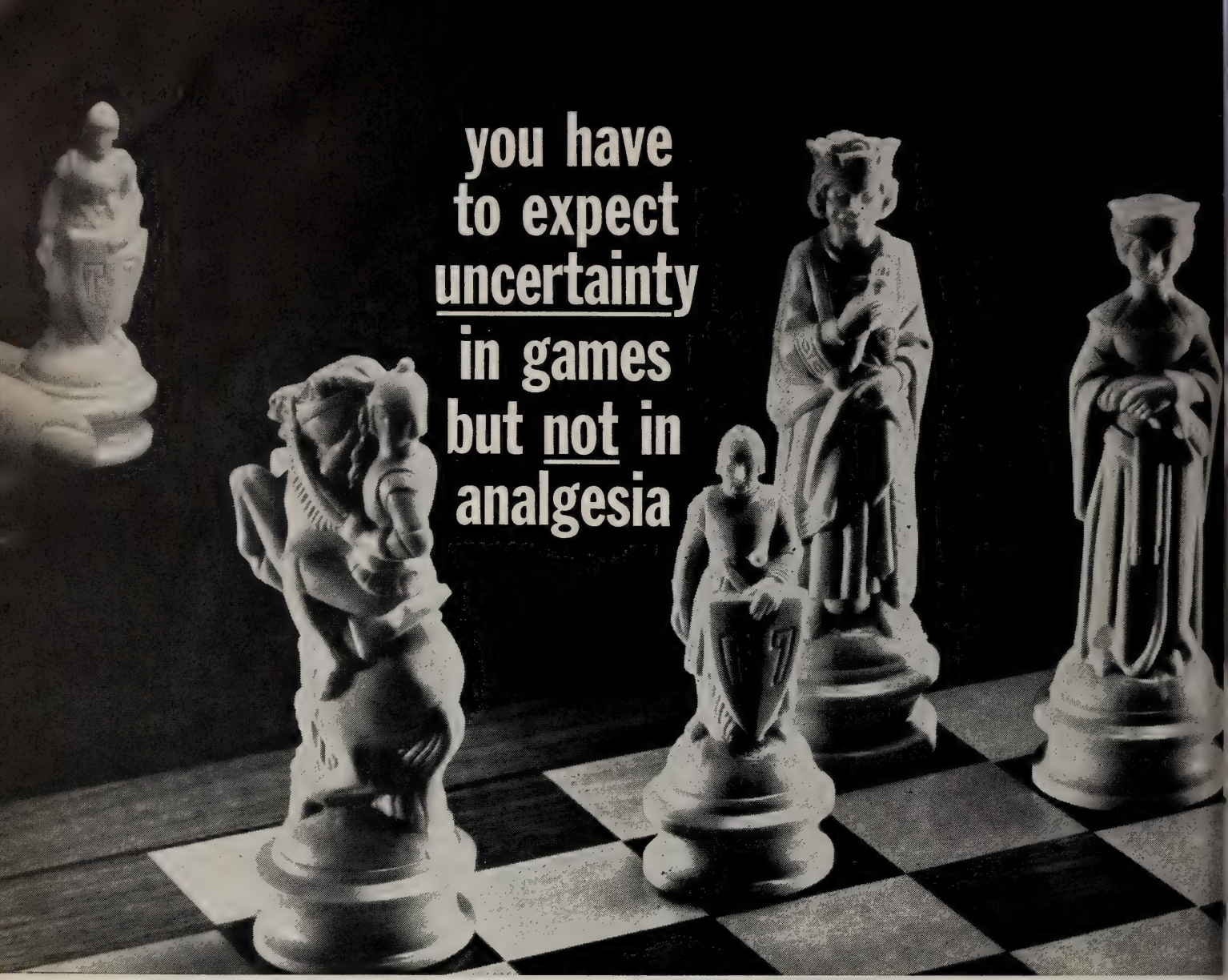
Second only to his interest in the war effort was his concern that Ohio's permanent seat of government be wisely chosen. Almost every area had its "favored site" but the two top contenders were Chillicothe and the "high land on the East Bank of the Scioto opposite Franklinton." Rogers, recognized as an intelligent, able man who had no prejudicial connection with either Franklin or Ross County, was made chairman of a committee to choose a site. This appointment, coming when he had been a member of the Senate less than a month reflects both the confidence he inspired in his associates and the desire of others to escape the responsibility of directing this very hot issue.

(To Be Continued in March Issue)

References

1. Everts, L. J.: *History of Clermont County, Ohio,* Philadelphia: J. B. Lippincott Co., 1880, p. 142.
2. *Ibid,* p. 144.

ATTENTION PROGRAM CHAIRMEN: We are most anxious to receive for consideration manuscripts, abstracts, or news items based upon lectures, symposia, etc., presented to Ohio physicians or those presented by Ohio physicians to other groups. — THE EDITOR.



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Emotional Problems of Children Attending a Heart Clinic*

BERNARD SCHWARTZ, M.D., BRIAN J. McCONVILLE, M.D., and SANDRA TONKIN, B.A.

RECENTLY, there has been considerable interest in the general topic of prevention in the fields of medicine and of social science. In psychiatry, this interest is proven by the rapid growth of concepts and practices in community mental health. In describing this, Bellak[1] (1964) says that "community psychiatry can best be defined as the resolve to view the individual's psychiatric problems within the frame of reference of the community and vice versa."

Following on this, the medical and psychology staffs at the Max and Martha Stern Heart Clinic became more interested in the "total diagnosis" of children attending this Clinic for investigation of suspected heart lesions. For years it had been the conviction of the senior author (B. S.) that children who were given the label of having organic heart disease faced considerable emotional problems. Furthermore, children who had heart murmurs or other evidence of cardiac abnormalities but who were finally assessed as having no "organic" heart lesions were placed in a position of chronic anxiety about their actual status with respect to activity, further life patterns, and so on. The plight of these children had been recognized at this Heart Station for some time and it has been customary to provide them with a letter which reassured both themselves and other interested persons about the true state of their "heart condition."

Caplan[2] (1964), who has an especial interest in the prevention of emotional disorders in children, has remarked that all physicians who deal with children "probably feel that the mental health of children and their families is an integral part of pediatric practice. It is certainly not a topic which has to be restricted to the practice of child psychiatrists and psychologists." Writing about the rehabilitation of chronically ill children, he thinks the physician "should capitalize on the strengths of the children and reduce their disability to realistic levels, and should try to avoid the extra disability produced by superadded irrational fantasies and stereotyped global helplessness or by fantasies of general crippling."

Socioeconomic Consideration

At this point, it might be instructive to comment further on the type of child seen at this Clinic. The children usually come from the lower socio-economic

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*This Clinic is under the auspices of the Cincinnati Health Department, and is subsidized by the Max and Martha Stern Heart Fund, also aided by the Southwestern Ohio Heart Association.
Submitted October 13, 1965.

neighborhood adjacent to the Clinic, which is situated in one of the downtown "core" areas of Cincinnati. The white children are often of migrant Appalachian stock. The father is infrequently employed at laboring jobs but is present in the family, usually in a dominant position. The mother is prematurely aged from having too many children too soon and tends to show evidence of repression and masochism. Both boys and girls mature early and often have marked sexual concerns. The Negro children have a somewhat different background. The father is often absent or non-providing; he may be present in the home at intervals but drinks often and withdraws under tension. The mother is the more "powerful" member of the family. She often makes the decisions and collects the welfare payments. The society is on the whole a matriarchal one. The children have a less obvious interest in sexuality but often show concern about whether food or love will be available. (The above comments are, of course, gross generalizations and are only intended to provide some flavor of the groups from which these children come.) As a whole, both groups are given to acting out behavior, and psychosomatic concerns are prominent.

As we got to know these children better in terms of the "total diagnosis," we were impressed with the frequency with which they showed patterns of anxiety or other emotional upset related to their supposed heart lesions. For example, one teenager, a white girl with no serious cardiac disease, came in with complaints of chest pain and shortness of breath, which were not related to exercise but apparently to the recent onset of menses and to the mutual concern which she and her mother felt about the daughter's achieving puberty. Another, a Negro boy who had no demonstrable heart disease complained of severe chest pain. He could be reassured about this, but his rage toward his father (which this symptom represents) had to be dealt with in several psychotherapy sessions. As a third example, a little girl with a definite congenital heart defect was so afraid of hospitalization and operation that her total personality showed signs of severe constriction.

Procedure

As a result of these preliminary observations, we decided to construct a study which might evaluate further some of the emotional factors associated with heart disease in these children.

We, therefore, chose to investigate three groups. Group I consisted of children who finally proved to have organic heart lesions (the "organic" group). Group II consisted of children who were referred because of some cardiac sign or symptom but after the usual cardiac tests, proved to have no evidence of organic heart disease and, therefore, no life threatening cardiac problem (the NOHD group). Group III consisted of children from a nearby day center, who had no known or suspected heart disease (the "normal or "control" group). Normality in this instance refers only to the status of the heart and does not imply normality in any other sense, i. e., a child could be classified as normal in our study if his heart were normal even though he might have signs of abnormality in other areas such as mental health.

Fifteen children were selected for study. Five had definite organic lesions; five had had suspected organic lesions, but were diagnosed as having no organic heart disease; and the remainder had no actual or suspected cardiac lesions.

Each child was given an intensive psychiatric and psychological evaluation which consisted of a psychiatric interview;* a short form of the Wechsler Intelligence Scale for Children (WISC); the Rorschach or inkblot test; the House-Tree-Person (HTP) test;† and the "Heart-Inside A Person (HIAP) test.‡

Group I (the organic group)

We felt that the group with definite heart disease might have been exposed to some or all of the following:

1. Moderate decrease in activity
   a. from doctor's orders or
   b. because of some physical distress on exertion;
2. Current or impending cardiac examination or operation; and
3. Personal or family trauma arising from the above.

In their fantasies, the organic group showed marked somatic concerns but, on direct questioning, denied any concern about their health and their bodies. This indicates both their anxiety and their use of denial in coping with that anxiety. Anxiety about the heart and its functions was denied particularly except in one psychotic child. These children were further characterized by their general constriction, negativeness, fragmentation, and limited body awareness.

Case Report from Group I

The following case history is illustrative of the organic group.

R. W. is a 12 year old Negro boy in the sixth grade and a B student. He is the third in a sibline of six and has two brothers and three sisters.

He was first referred at the age of 9, when routine school examination disclosed a systolic heart murmur.

On examination at the Clinic the patient was described as a well-built boy who showed no symptoms of unusual fatigue or dyspnea. He did not appear ill. There was a slight bulge in the precordium. On auscultation a systolic ejection murmur was heard over the pulmonic area. The second sound over this area showed increased splitting, which narrowed during expiration. There was an early diastolic third sound along the left sternal border followed by a diastolic murmur, which was not of blowing quality.

The electrocardiogram showed a slightly prolonged P-R interval (0.2 sec.), and precordial leads showed an RSR pattern in lead V_1, suggesting outflow tract hypertrophy of

*The psychiatric interview was given to both experimental groups but was not given to the normals. The psychiatrist, however, evaluated the tests for all three groups.

†This is a test in which the subject is asked to draw a house, a tree, and a person (no instruction as to the sex of the person to be drawn is given and we requested that the subject draw a person of the opposite sex when the first picture had been completed).

‡This consists of an outline of a person: the subject is asked to draw a heart inside.

the right ventricle. Later phonocardiography confirmed the auscultation findings. Similarly, cardiac fluoroscopy confirmed evidence of increased pulsation of the right descending pulmonary artery consistent with a left-to-right shunt. There was no definite evidence of left atrial or left ventricular enlargement. The enlargement of the right ventricle was equivocal. The clinical picture suggested atrial septal defect, and it was felt that the defect was small.

When seen subsequently, the patient continued to be asymptomatic and gave no complaints on interrogation.

On psychiatric study, R. W. proved to be a very attractive and verbal Negro boy. He said that he had a heart murmur and that his heart had "too many beats."

He denied worrying about his heart even though he said that it "keeps him alive." There is no restriction in his athletic performance.

On further questioning he did admit to being " a little worried" about the "little hole in the heart."

Things at home were "satisfactory" but then he looked sad and said that his father had died when he was 10. (It emerged later that his father had been ill for three years and had finally died from the effects of abdominal carcinoma.) He missed his father a lot and cried "sometimes." His mother was a "nice lady" and he got on well with the siblings. His main problems were that they had difficulty getting enough to eat (on Social Security) and that he had no "daddy" and wished that he did. For his three wishes he wanted a bike, a basketball, and a basketball hoop, three masculine objects which indicated at some level he hoped to overcome his depression and wanted to do things appropriate for his age. However, there was a quality of hopelessness about these longings. He had some indefinite plans to be married eventually and had a girlfriend his own age.

He was given a diagnosis of mild anxiety neurosis with unresolved grief and depression about his father's death. There was marked denial of stressful and threatening events, especially in terms of his heart. Indeed, it was striking how he had "walled off" his concerns about his heart so that other areas involving mastery and strength could develop to a limited extent. His depression seemed to center about his feelings about the loss of his father and about his own outlook in terms of his heart condition. It was felt that he needed a chance to ventilate his feelings and overcome his depression by talking about his fears about his heart and about his anger at his father for dying.

On psychological examination the patient seemed listless and apathetic. This was due in part to depression that he was still experiencing about the death of his father and was undoubtedly reflected in his test results.

His estimated I. Q. score was 75, but it was felt that under better conditions he might raise this to the normal range, which would be more in keeping with his school grade record. Nothing bizarre or peculiar was noted, but he did show some underlying concern for words with aggressive connotations.

His Rorschach is meager, seven responses in all. He showed great difficulty in comprehending what was expected. For example, when asked to trace his finger around the outline of the chest response to card I, he ran his finger around his own chest. It was noted that three out of the seven responses were anatomy responses, which is unusual for a record of this size. His other responses were of good form and no bizarre tendencies were noted.

His HTP is quite descriptive. His house is described as being made of glass indicating possible feelings of insecurity about his home situation or about his own body. The human figures are both in fighting positions reflecting perhaps both his own aggression and the perceived aggression of others toward him. The barrenness of the tree, tall limbs stretching up with no leaves or fruit, might indicate the young boy's needs left unsatisfied.

In the HIAP his heart is a relatively healthy looking valentine and is described accurately as to function and as being in a healthy condition.

Group II (NOHD)

The NOHD children generally appear to have manifest diffuse anxiety which is centered around their own bodies. There is an apparent hyperresponsiveness to humans, but this is expressed through fear of grown-ups and rage over dependency. These children also show a fear of growing up or adulthood and a general fear of the unknown which encompasses both fears of growing up and fear of sexuality.

Case Report from Group II

The following case history is illustrative of the NOHD group.

M. G., a 12 year old Negro boy, has an older and a younger sister. He comes from a lower class family. His father is a technician in a nearby hospital.

The boy came to the Clinic complaining that "they heard a strange noise in my chest." The referring physician, who had seen the boy during routine school examinations, had heard a precordial murmur.

On examination at the Clinic, the physician found a normal, well-developed boy of 11 years of age. A grade II systolic ejection type murmur was heard best in the third intercostal space along the left sternal border. It was not present after exercise. There were no other physical abnormalities.

An electrocardiogram and a chest roentgenogram were normal. Repeated physical examination confirmed the original impression of "no organic heart disease." A possible atrial septal defect was considered in the differential diagnosis, but no supporting evidence was found.

On psychiatric examination M. G. appeared as a bright and attractive Negro boy who related very easily to the examiner. He said that the doctor had "heard a strange noise in my chest." This had come "from my heart." "People who have noises in their hearts get operated on." "The heart pumps air and you need a heart to live." Dr. S. had recently told him that his problem wasn't major, and he felt much better about this.

Some examples of the topics and responses of the interview are as follows: M. G. had "no feelings" about being the only boy. He said his father was nice and never grouchy (although his eyes filled with tears when he said this). His mother was nice, and he helped her with the dishes.

He described two wishes:

1. He would like to go to college and to do engineering and sports. He also thought of being an F. B. I. agent.
2. He would like "nothing to happen to my heart."

If he were an animal, he would like to be a dog, because a dog always gets along with people and people always like him.

In his daydreams, he dreamed of passing his exams and of what he is going to do when he grows up.

On the basis of this and other material, he was given a diagnosis of "childhood neurosis with open anxiety centered about the heart. Other features are denial and rationalization." It was commented that M. G. seems to be extremely concerned about himself and his heart. He equates failure of his heart with death, and he is clinging to the idea that nothing "major" is wrong with him. He tends to deny feelings, especially anger, and wants to be loved and taken care of. However, this denial does not lead to an overall constriction of his personality. One of his ways of pleasing is to do well in school. This mechanism could be useful, since he is a bright boy who could achieve well there. He tends to think of increasing knowledge as a "shield against danger" rather than as a sign of increasing competence and skill. Nevertheless, he is able to plan ahead, and his neurosis is not so incapacitating as to impede further maturation.

On psychological examination, the patient appeared as a bright, cooperative 12 year old. His estimated I. Q. is 135, which puts him in the superior range. There was nothing abnormal noted in his responses on the WISC, but he did demonstrate high achievement needs evidenced through a tremendous desire to give all the possible right answers to the questions.

His Rorschach indicates a great need for empathic relations with a male identification figure. He is overly concerned with finding human form or attributes throughout the test, even at the expense of what might be a more popular or appropriate response. He exhibits a great deal of creativity and originality, which would support his high achieve-

ment needs and indicates that he uses his intellectual abilities to cope with impulses.

His HTP also indicates high achievement needs. His male is not as fully developed as the female in terms of certainty of characteristics and this supports that there is some difficulty in male identification.

His heart is a rather small valentine with arteries coming out from it. He describes its function accurately and states that it is healthy.

Group III (the "normal" group)

The normal group is made up of five children with no known or suspected heart problems. These children show initial anxiety, but this seems attributable to the testing situation. There are no definite characteristics that these children have in common, but there is some tendency for them to display passive-aggressive traits, insufficiently formed body awareness, and an overstrict conscience.

Quantitatively, it was found that, with one exception, the intelligence level of all three groups, was in the dull-normal range. Comparing the groups using Rorschach scoring, we also found that the "organic" group was more constricted in their approach to life situations, while the NOHD group was more openly anxious and tended to use repression (unconscious forgetting) devices. The normals showed no consistent response patterns. The results with the HIAP and the HTP tests tend to support the above findings.

Conclusions

This pilot study demonstrates the facts that the organic group is more constricted, makes more use of denial, and has more marked somatic preoccupations than the other two groups. The NOHD group displays a great deal of manifest (open) anxiety and hypersensitiveness to people, which is not found in the organics or normals. Hence, we conclude that these data do differentiate between the three groups and that these differences are due to or contribute to the heart problems.

Practically, it is felt that both experimental groups show a need for counselling and guidance. The child with an organic heart lesion must learn to accept and live with his affliction. He must not only learn to limit his activities but to accept and utilize other potentials to compensate for those which must be curbed. Ordinarily a child with a congenital heart defect does not shine as a star athlete. He does not get the usual life insurance coverage and frequently is defined a poor risk as a job holder.

However, a child in the NOHD group must also be given special consideration. He is in the peculiar position of being a suspected heart case. This means that although medical personnel disprove organic pathology and accept the NOHD diagnosis, the doubt has already been raised in the mind of the child, his family, and other interested persons (e. g., the school). Whether it be in applying for a job or going out for some athletic event, he will be faced by people reluctant to use his talents because of their fear that he will be unable to perform in the future due to heart problems. To identify this group of NOHD cases itself justifies any screening program because the ratio is 10 NOHD to 1 organic heart disease.

Both groups need intensive guidance and follow-up from psychiatrically oriented cardiologists, family physicians, psychiatric personnel, and others.

One of the specific problems to be dealt with in any future research in this area is that of chronicity. It has been suggested that one factor that was ignored in our original control group was the question of the effects of long-term illnesses on personality. To correct for this another control group would have to be studied. This should be a group of children who have the features of chronicity but who are not subject to a life threatening illness (e. g., chronic skin problems).

Suggested References

1. Bellak, L.: "The Third Psychiatric Revolution," in Bellak, L. (ed.): *Handbook of Community Psychiatry and Community Mental Health.* New York: Grune and Stratton, 1964.

2. Caplan, Gerald: "Pediatrics and Community Mental Health," in Bellak, L. (ed.): *Handbook of Community Psychiatry and Community Mental Health,* New York: Grune and Stratton, 1964.

PSYCHIATRIC COMPLICATIONS OF HEART SURGERY.—A psychosis of the acute organic variety occurred in 38 per cent of 99 adult patients subjected to open-heart surgery at the Columbia-Presbyterian Medical Center. A major factor appeared to be the environment of the open-heart recovery room, where intensive nursing and medical care produced an atmosphere of sleep and sensory deprivation. The clinical picture closely resembled the syndrome reported in experimental situations of sleep and sensory deprivation. Modifications in the structure and procedures of intensive-care units are suggested to diminish this effect. — Donald S. Kornfeld, M. D., Sheldon Zimberg, M. D., and James R. Malm, M. D., New York City: *The New England Journal of Medicine,* 273:287-292, August 5, 1965.

Abstracts from Regional Meeting of American College of Physicians

EDITOR'S NOTE: Again this year *The Journal* is pleased and proud to publish abstracts of the papers read at the Combined Regional Meeting of the American College of Physicians for Ohio, West Virginia, and Western Pennsylvania November 19 - 20, 1965, in Pittsburgh, Pennsylvania. The abstracts present in concise form a wealth of information reflecting the nature of current medical research in this part of the country. We are indebted to Dr. Gerald P. Rodnan and his Program Committee for the selection of the papers and to them and Drs. Richard W. Vilter, Edmund B. Flink, and William M. Cooper, Governors of the College for Ohio, West Virginia, and Western Pennsylvania respectively, for permission to publish the abstracts.

* * *

Clinical Syndromes and Selective Cine-Coronary Arteriography

William L. Proudfit, M. D., F.A.C.P., Earl K. Shirey, M. D., (Associate), and F. Mason Sones, M. D., (by invitation).

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio

On the basis of independent review of the clinical records and selective cine-coronary arteriograms in 1000 patients, the following conclusions were reached:

1. Symptomatic coronary disease is accompanied by arteriographic evidence of significant obstruction of major coronary arteries.

2. About 95 per cent of patients diagnosed as having angina pectoris functional Class I-III had significant objective disease.

3. Obstructive lesions were encountered in about 99 per cent of patients who showed QRS abnormalities considered indicative of myocardial infarction.

4. The obstructions found were almost always severe in patients who had angina pectoris functional Class I-III and were always severe in patients who had myocardial infarction.

5. A high correlation (87 per cent) existed in patients who had angina functional Class IV.

6. Poorer correlation was noted in patients thought to have anginal pain at rest only, coronary failure (coronary insufficiency) and especially atypical angina pectoris.

7. Most patients thought to have non-coronary pain had normal arteriograms.

8. In congestive heart failure secondary to coronary disease, arterial obstruction was extensive and severe unless there was a complicating condition, such as ventricular aneurysm, mitral insufficiency, arrhythmia or arterial hypertension.

9. About 37 per cent of the 1000 patients had no significant arteriographic abnormalities; most of these had been thought to have coronary disease by at least one physician.

* * *

Coronary Arteriovenous Fistula and Aortic Sinus Aneurysm Rupture

John C. Holmes, M. D., (Associate), Noble O. Fowler, M. D., F.A.C.P., and J. A Helmsworth, M. D., (by invitation).

From the Department of Medicine, Cincinnati General Hospital, Cincinnati, Ohio

In local experience coronary arteriovenous fistula or aortic sinus of Valsalva aneurysm rupture into the right heart are the two common causes of acquired continuous murmurs with systolic accentuation which are maximum over the lower sternum. This report describes three patients with coronary arteriovenous fistula subjected to successful surgical repair and five patients with anatomically verified aortic sinus rupture, two of whom had successful repair.

Coronary arteriovenous fistula. Two patients were 20 year old women. The third was a 24 year old man. Two had increased arterial pulse pressure and heart failure, and each had cardiac enlargement. The dilated right coronary artery was demonstrated by aortography to communicate with the right ventricle in each instance. Surgical correction was followed by disappearance of the murmur and decrease in heart size.

Aortic sinus aneurysm rupture into the right heart. Each of the five patients demonstrated increased arterial pulse pressure and cardiac enlargement. Three had sudden onset of dyspnea. Three had congestive

heart failure and one developed complete A-V block. Right heart catheterization demonstrated entry of oxygenated blood into the right atrium or ventricle. Successful repair was carried out in two females, 14 and 22 years of age. In three men, age 40 to 66 years, the communication caused eventual death because of congestive heart failure, pulmonary hypertension, or complete A-V block.

* * *

Electrocardiographic and Arteriographic Features of Posterior (Infra-atrial), Posterolateral and Posteroinferior Myocardial Infarctions

R. C. Lewis, M. D., M.R.C.P., (by invitation), and William L. Proudfit, M. D., F.A.C.P.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio

When present, the ECG manifestations of myocardial infarction are specific. Anterior and inferior infarctions are usually readily diagnosed as they are accessible to conventional exploration. Posterior infarctions, with or without inferior or lateral extensions, are frequently "missed" as the diagnostic changes may not be apparent on the conventional ECG. Pathologic Q waves are noted when posterior leads are recorded, and in Vf and/or V6 if extension is present.

Suggestive changes may be seen in right precordial leads:

(a) S-T segment depression

(b) Peaked T waves

(c) Tall upward deflections with R/S ratio greater than 1.

Changes *a.* and *b.* occur in the acute stage; *c.* is usually persistent. The study included 96 individuals:

A. *40 patients* — diagnostic Q waves in back leads, no changes in right precordial leads.

B. *27 patients* — diagnostic Q waves in back leads, suggestive changes in right precordial leads.

C. *29 patients* — diagnostic Q waves in Vf and/or V6 and posterior leads. Additional changes noted in right precordial leads. Coronary arteriography was performed in 16 cases.

* * *

Experience with the Radio EKG

Gordon M. Mindrum, M. D., F.A.C.P.

From the Department of Medicine, University of Cincinnati College of Medicine, and General Electric Company, Cincinnati, Ohio

The radio EKG was evaluated in 30 normal subjects and 49 persons with heart disease, 37 of whom had at least one myocardial infarction.

The radio EKG is slightly larger than a package of cigarettes and may be carried in the pocket while the person is walking, running, working, or sleeping. This FM radio transmits a radio signal of the EKG to a desk model receiver from which an EKG may be written by a standard EKG machine. The EKG could also be visualized on an oscilloscope or could be recorded on tape for later playback or computer analysis. All subjects were given detailed cardiac examinations, chest x-rays, standard 12 lead electrocardiograms and 4 lead phonocardiograms.

Radio EKG tracings were obtained in the resting position and the subjects were permitted to do varying amounts of work. The heart was monitored for minutes, hours or days. Normal and abnormal responses were established.

The radio EKG permits insight into the functional capacity of the heart for work which the standard EKG cannot give. It is a practical device to help evaluate the cardiac reserve after myocardial infarction.

* * *

Postcardioversion Ventricular Tachycardia

J. A. Shaver, M. D., F. W. Kroetz, M. D., J. F. Lancaster, M. D., D. F. Leon, M. D., (all by invitation), and James J. Leonard, M. D. (Associate).

From the Department of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania

In our series of 84 synchronized countershocks in 67 patients, ventricular tachycardia (VT) occurred in the immediate post-countershock period in three patients having chronic atrial fibrillation (AF). During cardioversion, two patients, post-mitral commissurotomy, developed recurrent episodes of VT. One patient had three successive bouts, each terminated by countershock, ultimately stabilizing to the previous AF. In a second patient six such arrhythmias were terminated by six countershocks. Stable sinus rhythm occurred only after the infusion of 750 mg. procaine amide during the final three episodes. A third hypertensive patient developed VT which reverted to the previously present AF after single countershock. Every patient received quinidine sulfate prior to cardioversion. All received cardiac glycosides, but in only the third case could possible digitalis intoxication be implicated. Light sodium Pentothal® anesthesia was used. In each patient, following the initial countershock, normal sinus beats were observed prior to spontaneous development of VT, thereby ruling out improper synchronization of the discharge. After final reversion there was no subsequent instability of cardiac mechanisms.

In summary, single or recurrent episodes of VT have occurred in 4 per cent of 84 cardioversions. Although the etiology is as yet undefined, digitalis intoxication is not felt to be responsible.

* * *

Pneumococcal Endocarditis at the Cincinnati General Hospital In the Penicillin Era

Allen L. Straus, M. D., (by invitation), and Morton Hamburger, M. D., F.A.C.P.

From the Department of Medicine, University of Cincinnati College of Medicine

A significant reduction in the incidence of pneumococcal endocarditis has occurred since the introduc-

tion of penicillin. Though the prognosis of pneumococcal endocarditis was hopeless before the discovery of penicillin, evaluation of the impact of penicillin therapy upon prognosis has been hampered by the low incidence of the disease. The records of 15 cases of pneumococcal endocarditis treated at the Cincinnati General Hospital from 1945 to 1965 were reviewed; all received penicillin. Twenty-nine cases of penicillin-treated pneumococcal endocorditis from the English language literature were also reviewed.

Analysis of factors which may have influenced survival revealed:

1. There was no significant difference between the quantities of penicillin received by survivors and nonsurvivors of the acute illness. Cure was obtained with as few as 0.12 x 10^6 units of penicillin daily. The average duration of penicillin treatment in survivors was 22 days.

2. The prognosis did not seem to be affected by delay in diagnosis of endocarditis.

3. A uniformly higher mortality existed among those with symptoms of shorter duration even though endocarditis was recognized early and treated.

4. Eighty per cent of patients with aortic endocarditis and 70 per cent of patients with mitral endocarditis died. In contrast, only one of three patients with tricuspid endocarditis and no patient with an infected congenital cardiac lesion died.

* * *

Cephaloridine Treatment of Bacterial Infections

R. L. Perkins, M. D., M. A. Apicella, M. D., (both by invitation), and Samuel Saslaw, M. D., F.A.C.P.

From the Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio

Cephaloridine is an investigational semisynthetic antibiotic derived from cephalosporin C. The chemical structure differs from cephalothin (Keflin) only in substitution of pyridine for an acetoxy group at position 3. Cephaloridine is reported to differ from cephalothin in possessing measurably greater antibacterial activity against Gram-positive bacteria, greater solubility, less protein binding, and results in comparatively higher and more prolonged serum levels after intramuscular injection.

Ninety-two patients were treated with cephaloridine. Therapy was successful in 65 (94 per cent) and 17 (74 per cent) of Gram-positive coccal and Gram-negative bacillary infections, respectively. Twenty patients with histories of penicillin allergy showed no reactions to cephaloridine. Serial serum levels obtained from 10 volunteers after 1 Gm intramuscularly ranged from 5.5 to 28.8 mcg/ml at 15 minutes, 10.6 to 29.5 at 30 minutes and at six hours concentrations of 4.1 to 7.9 mcg/ml were still present. *In vitro* studies showed that the median minimum inhibitory concentrations for penicillin resistant and sensitive staphylococci were 0.235 mcg/ml and 0.120 mcg/ml, respectively, and median bactericidal concentration for both was 7.8 mcg/ml; 0.095 mcg/ml or less was bactericidal for pneumococci and group A streptococci. Enterococci. klebsiella, *E. coli, P. mirabilis* and 11 salmonella strains were more resistant, but cephaloridine showed bactericidal action on 50 per cent of these organisms at concentrations readily achieved *in vivo*. These studies demonstrate that cephaloridine is a safe effective antibiotic for Gram-positive coccal and selected Gram-negative bacillary infections. It is particularly useful in penicillin-allergic patients.

* * *

Evaluation of the HIM (Hepatitis–Infectious Mononucleosis) Test

Donald R. Weaver, M. D., (by invitation), and John W. King, M. D.,F.A.C.P.

From The Cleveland Clinic Foundation, Cleveland, Ohio

The HIM test is a new test for agglutinins in the serum of patients with hepatitis and infectious mononucleosis, which was developed by Bolin in 1963. Virus coated latex antigens are prepared using virus isolated from patients with serum hepatitis. These viruses as well as viruses from patients with serum hepatitis and infectious mononucleosis were isolated and propagated in human embryonic lung tissue culture systems by Bolin. He demonstrated that these viruses were serologically identical by neutralization and complement fixation tests.

The present authors describe their experience with this antigen. The agglutination test is simple, can be performed rapidly, and appears to hold promise as a screening test to detect carriers of serum hepatitis among blood donors and as an aid in diagnosing hepatic disease. Positive reactions were found in five patients out of five studied with active infectious hepatitis, five of five with serum hepatitis, five out of five with a history of hepatitis, and 11 of 12 patients with infectious mononucleosis. An incidence of 38 per cent positive reactions in 47 other patients from the G. I. service approximates that of 42 per cent found in a random sampling of 150 control subjects. The group of 47 includes a wide spectrum of hepatitis disease.

Liver biopsies were obtained in 22 patients and correlated well with the HIM test. With further experience, it appears that it will be useful in the differentiation of the various types of cirrhosis.

* * *

Serologic Reactions and Serum Protein Concentrations in the Aged

Roy J. Cammarata, M. D., (by invitation), Gerald P. Rodnan, M. D., F.A.C.P., R. H. Fennell, Jr., M. D., and Alice S. Creighton, B. S., (both by invitation).

From the Department of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania

The present report is based on study of the serum protein concentrations and latex agglutination and anti-nuclear factor reactions in a group of 325 in-

dividuals 70 years of age and over. *Latex agglutination:* there was a total of 52/325 positive reactions (16 per cent), with titers 1:160 or greater in 20 cases. There was no significant difference in number of positive reactions between men and women, but the frequency was twice as high among patients at the Jewish Home for the Aged compared to non-Jewish patients. *Anti-nuclear factors:* there was a total of 93/255 positive reactions (37 per cent), as determined by indirect immunohistochemical method utilizing human tissue. There appeared to be no significant difference in the number of positive reactions between men and women or between different ethnic groups, except for a somewhat higher frequency among Jewish women (27/58, 46 per cent). *Serum proteins:* total serum protein concentration in 90 of the patients was slightly lower than that previously observed in a group of 50 healthy young adults, this difference being accounted for by a lessened amount of albumin. In contrast, the concentration of gamma globulin was slightly greater in the aged (average 1.15 Gm/100 ml) compared to the younger group (average .96 $\pm$ 0.22 Gm/100 ml). The concentration of gamma globulin was significantly greater in those aged individuals who showed positive latex agglutination reactions. *Clinical findings:* 17 of the aged patients had possible, probable, or definite rheumatoid arthritis, and 10 of these had latex agglutination titers of 1:160 or greater. The majority of individuals with positive latex agglutination and anti-nuclear factor reactions had no evidence of rheumatoid arthritis or other systemic rheumatic disease.

* * *

Azathioprine Therapy in Rheumatoid Arthritis

Vol K. Philips, M. D., F.A.C.P., Norman O. Rothermich, M. D., F.A.C.P., and Howard W. Marker, M. D., (by invitation).

From The Columbus Medical Center Research Foundation, Columbus, Ohio

The immunosuppressive effect of oral azathioprine was tested in 25 patients with classical or definite rheumatoid arthritis. All patients had active progressive disease, worsening despite adequate therapeusis including salicylates, gold, and steroids. Clinical evaluations were obtained semimonthly and comprised the Systemic Index, Articular Index, and adjunctive medication requirement, hematologic, biochemical and serologic data. Azathioprine dosage averaged 100 milligrams daily.

Serial bloods were tested for Bentonite and Fluorescent antibodies to DNA and RNA, for changes in titre of rheumatoid factor, and for electrophoretic patterns of hyperglobulinemia. Also performed were corollary determinations of drug effect upon other antibodies in most adults (i.e., protective antibodies against typhoid antigen).

RESULTS: Azathioprine is a well tolerated drug and produces no dangerous toxicities at a dosage of 100 milligrams daily. Therapeutic effects are slow in onset, but of prolonged duration. Discontinuance of prednisone was accomplished in three patients previously requiring an average of 6.4 mg. per day for reasonable clinical control of rheumatoid arthritis. Prednisone dose reduction by 24 per cent was accomplished without loss of prior clinical response in 9 of 20 patients previously requiring prednisone control. Azathioprine supplanted gold therapy without loss of clinical effect in eight. Anti-RNA and anti-DNA antibodies, when present, were not significantly altered by treatment with azathioprine in the dosage given. Azathioprine may exert a suppressive effect upon activity of rheumatoid arthritis and upon certain other auto-immune rheumatic diseases, as well as upon the demonstrated immune processes involved at higher dosage levels than given in this preliminary study.

* * *

The Effects of Food, Fast, and Alcohol on Serum Uric Acid Levels and the Occurrence of Acute Attacks of the Gout

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From the Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Despite the age-old belief that acute gouty arthritis is often precipitated by over-indulgence in food and drink, relatively little is known concerning the effects of alcohol on uric acid metabolism in patients with gout. The hyperuricemia which occurs during therapeutic fasts and that which follows ingestion of alcohol have recently been attributed to elevations, respectively, in the blood levels of beta-hydroxybutyrate and lactate, both of which substances inhibit urinary excretion of uric acid. Eight gouty patients and one normouricemic person were admitted to a metabolic ward and subjected to 1 - 2 day fasts with and without administration of alcohol in the form of beer or whiskey. Following these brief fasts, there was a rise in serum urate concentration of approximately 1-2 mg/100 ml and in beta-hydroxybutyrate to levels as high as 58 mg/100 ml. When alcohol was taken with the low purine control diet there was a slight elevation in blood lactate but no change in serum urate level. However, when alcohol was consumed during periods of fasting, there was an even greater rise in serum uric acid and beta-hydroxybutyrate, than in fasting alone, as well as a significant elevation in blood lactate, which reached levels as high as 29 mg/100 ml. Seven patients experienced a total of 25 attacks of acute gouty arthritis during the course of study. These attacks occurred most frequently following a rapid change in serum urate concentration. When probenecid was given in a dose of 1.5 Gm. a day, similar changes in serum urate level were induced by alcohol and fasting but these were less striking in degree.

* * *

Stenosing Small Bowel Ulcers

N. Akin, M. D., (by invitation), and
Charles H. Brown, M. D., F.A.C.P.

From the Department of Gastroenterology, The Cleveland Clinic Foundation, Cleveland, Ohio

"Idiopathic," nonspecific ulcers of the small intestine have been rare until the discovery that enteric coated diuretics containing potassium (1964) could cause such ulcers. Since then, and with the use of such diuretics, there has been an increased incidence of small intestinal ulceration, and greater interest in this entity. Because of this interest, we have reviewed our cases of small intestinal ulceration.

Since 1953, we have seen 11 cases with primary ulcer of the small intestine. All of these patients were contacted and shown samples of enteric coated diuretics containing potassium, and only one had taken such a drug. One other patient received hydrochlorothiazide without potassium during menstrual periods, and another received enteric coated hydrochlorothiazide with potassium ten years AFTER previous surgery for primary small bowel ulceration. While it has been shown both clinically and experimentally that such diuretics containing potassium can cause small intestinal ulceration, nonetheless, the incidence of such ulceration must be low. The number of enteric coated potassium pills dispensed in one year by our Pharmacy:

(a) 48,000 Thiazide with K.

(b) 5,000 K enteric coated with Thiazide.

Small intestinal ulcers usually cause gastrointestinal bleeding (two cases), or obstruction (six cases), or a history of gastrointestinal bleeding followed by obstruction (three cases). So, a total of five patients had gastrointestinal bleeding and nine developed obstruction.

The possibility of a small intestinal ulcer must be considered in any patient with a history of bleeding in which it is difficult to determine whether they had melena or bloody stools. This is the same type of bleeding exhibited by some patients with a Meckel's diverticulum. Small intestinal ulcer must also be considered in any patient with symptoms suggesting obstruction — such as cramps, bloating, distention, vomiting, etc. A definite diagnosis can be made only by operation and pathological examination.

Primary ulcer of the small intestine must be differentiated from a number of other conditions causing the same clinical syndrome. The etiology of "Idiopathic, primary" small intestinal ulcer is unknown. Since the majority of recent cases reported had received enteric coated potassium, all patients suspected of having small bowel ulcer should be shown all the enteric coated potassium tablets to see if they have taken them. Our own incidence of such a drug reaction, however, is low, since we have seen only one patient (of eleven with small bowel ulcer) who had taken such a drug.

* * *

Effects of Norepinephrine on Gastrointestinal And Pancreatic Blood Flow in Hypotensive Dogs

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From the Department of Medicine, Montefiore Hospital and University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Although the use of vasoconstrictors in shock has been established for many years, this concept has been questioned because of the variable clinical response and the possibility that this therapy increases vasoconstriction and therefore tissue ischemia.

In an attempt to clarify this problem, blood flow was measured through various parts of the gastrointestinal tract and pancreas of dogs in whom this clinical situation was simulated. A previously established method for measuring local circulation through parts of the brain (Kety, SS., *Methods in Medical Research,* 8:22, 1960) was adapted to measure gut and pancreatic circulation.

Results were obtained in 6 normotensive unanesthetized dogs, 5 blood loss induced hypotensive dogs and in 4 dogs whose blood loss induced hypotension was corrected with I. V. Norepinephrine.

BLOOD FLOW
(cc/100 Gm Gut Tissue/minute)

	Control 6 dogs	Hypotensive 5 dogs	Norepinephrine 4 dogs
MABP (mm Hg)	118	52	109
Gastric	46±3.9	8.6±5	7.8±5.8
Small Intestine	55±6.8	23.0±3.1	12.1±2.4
Colon	60±10.2	22.8±4.1	8±2.8
Pancreas	51±3.3	Not Measured	5±2.0

The results reveal that blood loss induced hypotension caused a statistically significant decreased blood flow in all parts of the gut and pancreas.

Norepinephrine significantly decreased the blood flow in colon and small bowel even more, regardless of the return of the mean arterial blood pressure (MABP) to normotensive levels. Gastric blood flow did not change significantly with Norepinephrine therapy.

Therefore, hypotension causes tissue ischemia of all parts of the gut and Norepinephrine therapy accentuates this ischemia of all parts of the gut except the stomach. Gastric blood flow is not altered by I. V. Norepinephrine. Norepinephrine may produce this effect by increasing vasoconstriction in the gut or by opening more intestinal shunts. These results strengthen doubts concerning the efficacy of vasoconstrictor therapy in shock.

* * *

Isotope Pancreatography

D. Bruce Sodee, M. D., (Associate)

From Doctors Hospital and Renner Clinic Foundation, Cleveland Heights, Ohio

Pancreatic scanning with Selenomethionine-se 75 is a successful investigational tool. In a series of 205 patients for which 645 scans were performed, this procedure, in our hands, has had practical value in

the screening of patients suspected of having pancreatic carcinoma.

In the past, the only usual screening modality for pancreatic carcinoma was the upper gastrointestinal series that became abnormal far too late in the course of this disease. With scanning nine of our patients with pancreatic carcinoma had abnormal pancreatic scans without an abnormal upper gastrointestinal series.

* * *

Virus Infection and Kidney Transplantation

B. K. Khastagir, M.R.C.P., Satoru Nakamoto, M. D., (both by invitation), and W. J. Kolff, M. D., F.A.C.P.

From the Department of Artificial Organs, The Cleveland Clinic Foundation, Cleveland, Ohio

Fulminant and deadly viral infections have been observed in patients covered with immunosuppressive drugs to make kidney transplantation possible.

Six patients developed herpes simplex. The vesicles erupted on the lips, nostrils, and inside the mouth. In two cases the vesicles spread rapidly. In others the vesicles healed slowly in the course of three weeks. In three cases cytomegalic inclusion bodies were found at autopsy. In two cases the cytomegalic inclusions were found in the lungs, and in the third case they were located in the submucosa of the ureter. Similar viral disease has heretofore been described in debilitated newborn children and patients with leukemia or malignancy. The early recognition is of importance, since with reduction of immunosuppressive drugs, recovery, at least from the herpes, has occurred. These complications of kidney transplantation should be viewed against the background of our clinical experience. From January 1963 to August 1965, 84 kidneys were transplanted in 69 patients; 64 kidneys taken from cadavers were transplanted in 44 patients. There are now 31 functioning kidneys taken from cadavers, of which 17 are functioning for more than six months.

* * *

Rapid Progression of Untreated Pernicious Anemia in Postoperative Period

John B. Hill, M. D., (by invitation), and William M. Cooper, M. D., F.A.C.P.

From the Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

During the last two years, four patients have been seen in consultation because of rapid development of unexplained anemia two to ten weeks following a surgical procedure. Three patients had gastrointestinal surgery and one a hysterectomy. In each instance the anemia was megaloblastic. Two of these patients also had concomitant rapid progression of neurological changes typical of pernicious anemia. Schilling tests in the other two confirmed the diagnosis of pernicious anemia. In retrospect, all had mild anemia and/or leukopenia preoperatively but peripheral blood smears or bone marrow aspirates were not examined. Megaloblastic changes undoubtedly existed in all four prior to surgery. Tissue regeneration and thus DNA production is increased in the postoperative period as a result of tissue destruction during surgery. Since vitamin B-12 is vital for DNA formation, further depletion of already markedly reduced stores of this vitamin would be expected in the postoperative period. It is postulated that this sudden, additional depletion of vitamin B-12 was the etiology of the rapid progression of the manifestations of pernicious anemia in these four individuals. Although such a course would not be expected in most other hematological diseases, these cases again re-emphasize the importance of evaluating even slight hematologic abnormalities preoperatively.

* * *

Hemolytic Anemia Caused by Exposure to Hyperbaric Oxygen (OHP): Its Mechanism And Significance

Herbert E. Kann, Jr., M. D., and Charles E. Mengel, M. D., (both by invitation). (Introduced by Henry E. Wilson, M.D., F.A.C.P.)

From the Department of Medicine, The Ohio State University Medical Center, Columbus, Ohio

We observed hemolytic anemia (Hct. 48 per cent to 35 per cent, reticulocytes 0.5 per cent to 4.6 per cent, indirect bilirubin 0.5 mg/100 ml to 1.6 mg/100 ml) in a patient exposed to OHP (100 per cent O_2 at 2 atmospheres for 30 minutes). His RBCs before and after OHP contained no Heinz bodies, had normal methemoglobin and reduced glutathione content, and normal G6PD activity. However, during incubation with hydrogen peroxide his RBC lipid was peroxidized greater than normal and his RBCs lysed excessively. We subsequently studied the influence of an inhibitor of lipid peroxidation, alpha tocopherol, on the hematologic effects of OHP in mice.

Tocopherol supplemented mice exposed to 100 per cent O_2 at 4 atmospheres for 90 minutes demonstrated no RBC lipid peroxidation or lysis, whereas tocopherol deficient mice showed marked RBC lipid peroxidation followed by fall in Hct (45 per cent to 28 per cent), hemoglobinemia, and reticulocytosis. No decrease in reduced glutathione content or G6PD activity, no increase in methemoglobin content, and no Heinz body formation occurred.

These studies indicate that hyperoxic hemolysis is associated with peroxidation of RBC lipid rather than with overloading of usual oxidant protective mechanisms. Lipid peroxidation may be generalized biochemical response primary in the pathogenesis of oxygen toxicity and manifested overtly in our studies by hemolytic anemia.

* * *

Clearance of Infused Fibrin

Jessica H. Lewis, M. D., and Isabel L. F. Szeto, M. D., (both by invitation).

From the Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Intravascular formation of fibrin is associated with such diseases as thromboembolism, amniotic fluid em-

bolism, and abruptio placentae. Less obvious fibrin formation has been postulated following surgical procedures, injuries, and even as a normal everyday process involving constant fibrin formation and removal. The mechanisms of fibrin removal are not clearly understood, although much emphasis has been placed upon the role of the plasma fibrinolytic enzyme system.

To explore this process, finely particulate, iodinated fibrin was infused into dogs either arterially or intravenously. The fibrin I^{131} disappeared from the circulation within two minutes and shortly thereafter soluble I^{131} appeared reaching a maximum level by two to four hours after the infusion. In the first few hours most of the I^{131} was attached to large molecules (TCA insoluble). As time progressed more TCA soluble I^{131} was found in the plasma and the I^{131} content of the urine increased. Tissue studies suggested that fibrin was being degraded at the site of deposit. No changes in the plasma fibrinolytic enzyme system were found. Coincident infusions of heparin or a fibrinolytic activator enhanced the solubilization rate *but* infusion of the fibrinolytic inhibitor, EACA, did not prevent or decrease fibrin solubilization. It was concluded that fibrin could be degraded by a mechanism independent of the plasma fibrinolytic enzyme system and, perhaps, dependent upon phagocytic activity of vascular endothelium or leukocytes.

* * *

Autologous Bone Marrow Storage and Infusion in Patients Receiving Whole Body Irradiation

Ben I. Friedman, M. D., F.A.C.P.

From the Departments of Medicine and Radiology, University of Cincinnati College of Medicine, and Radioisotope Laboratory, Cincinnati General Hospital, Cincinnati, Ohio*

In an attempt to better understand clinical, hematological, psychological, physiological, metabolic, and chromosomal changes after whole body irradiation, patients with metastatic malignancies are being treated with up to 200 rad (336r) whole body radiation. Since severe hematologic manifestations of the acute radiation syndrome are encountered in patients receiving 150 rad or more, storage of marrow for autologous infusion has been instituted.

All patients have marrow stored by the method of Kurnick one to two weeks prior to irradiation. Aspiration is from the posterior iliac crest under local anesthesia. After the addition of Osgood-glycerol solution, the temperature of the mixture is reduced from ambient temperature by the Polge technique. Storage is at –80° Centigrade. After the addition of 33 1/3 per cent dextrose solution the bone marrow is infused intravenously without filtration at a rate of 50 drops per minute.

Marrow from nine patients has been stored. It has then been reinfused in three patients. Repopulation of the marrow space may have been successful in one case.

This procedure may be of clinical value in treating the hematologic complications of cytotoxic drug and radiation therapy.

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* * *

Utilization of Lymphangiograms in the Evaluation of Patients with Lymphoma

Marie Manno, M. D., and John B. Hill, M. D., (both by invitation).

From Western Pennsylvania Hospital, Pittsburgh, Pennsylvania

During the last year, retroperitoneal lymphangiograms have been performed in selected patients with lymphoma. Twelve patients, seven with Hodgkin's disease and five with lymphosarcoma, have been studied. No complications have occurred. Seven had positive lymphangiograms but in only one patient was the intravenous pyelogram suggestive of retroperitoneal involvement. Confirmation and localization of retroperitoneal disease in three patients with Stage III Hodgkin's disease was made by means of lymphangiograms and subsequent radiation therapy given to this area. Three patients with lymphosarcoma with suspected retroperitoneal disease, negative intravenous pyelograms, but positive lymphangiograms received radiation therapy to the demonstrated involved area. They would not have been treated in the absence of a lymphangiogram. Three patients with Stage II Hodgkin's disease and one patient with an epidural mass thought to be Hodgkin's disease had negative lymphagiograms and their therapy was limited to radiation to proven involved areas.

This small series of patients confirms that lymphangiograms are a valuable procedure in the evaluation of patients with lymphoma and superior to intravenous pyelograms in the demonstration of retroperitoneal disease. The procedure is relatively simple to perform, can be utilized in any hospital where patients with lymphoma are treated, and not limited to a University Center or similar institution.

* * *

Muscle Degeneration in Association with Apparent Vitamin E Deficiency In a Human

John W. Vester, M. D., and Leon R. Williams, M. D., (both by invitation). (Introduced by Gerald P. Rodnan, M. D., F.A.C.P.).

From Oakland Veterans Administration Hospital, and Departments of Medicine and Biochemistry, School of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania

A 48 year old man presented himself here six years ago with muscle weakness. This involved first upper and then lower extremities and was progressive in a cyclic fashion to the point where the patient was nearly bedfast. Muscle biopsy showed focal regeneration and sarcolemmal proliferation not consistent with progressive muscular dystrophy. In January 1962, creatine phosphate phosphokinase was 20 units per ml. compared to normal of 1 unit or less per ml. Creatine/creatinine was 0.8. Electromyogram data were felt to be compatible with muscular dystrophy. 100 mg. α-tocopherol orally three times daily,

given empirically, produced a slow but striking subjective return of muscle strength. All objective measurements except creatine/creatinine returned to normal values and this latter reached 0.22. Therapy was discontinued after 12 weeks and plasma tocopherol levels gradually declined to 0.06 mg/100 ml coincident with return of symptoms. All objective data were again abnormal. An I^{131} triolein study showed 7 per cent absorption and I^{131} oleic acid absorption was normal. Restoration of α-tocopherol therapy after 30 weeks without it produced striking improvement again. Strength has been maintained for two and a half years and he is now gainfully employed. The muscle biopsy, creatine excretion and serum creatine phosphokinase pattern during disease peaks was similar to those shown by α-tocopherol deficient rabbits in this laboratory.

These data suggest that this patient represents the first clear-cut instance of vitamin E deficiency in a human. The pancreatic lipase deficiency undoubtedly played a major role in the development of this syndrome but does not fully explain it.

* * *

The Relationship of Thyroid Function To Magnesium Metabolism

John E. Jones, M. D., (Associate), Paul C. Desper, M. D., Stanley R. Shane, M. D., (both by invitation), and Edmund B. Flink, M. D., F.A.C.P.

From the Department of Medicine, West Virginia University Medical Center, Morgantown, West Virginia

An evaluation of magnesium metabolism in eight hypothyroid and six hyperthyroid patients has been undertaken. Studies included determinations of serum and erythrocyte magnesiums, exchangeable magnesiums, and complete balance studies. Mean serum magnesium levels were decreased in hyperthyroidism and elevated in hypothyroidism. Urinary excretion of Mg^{24} and Mg^{28} was reduced in hypothyroidism and elevated in hyperthyroidism prior to therapy. Total exchangeable and cellular exchangeable magnesiums were low in hypothyroids and normal in hyperthyroids both before and after therapy. Hypothyroids were found to have negative sodium, potassium, magnesium, calcium, phosphorus and nitrogen balances with increasingly negative balance with increasing doses of triiodothyronine, while balance values were invariably positive in hyperthyroids during propylthiouracil therapy. Magnesium balance ranged from —15 to —221 mEq in hypothyroids and from +33 to +146 mEq in hyperthyroids. Prompt increases in urinary magnesium were noted in hypothyroids during triiodothyronine therapy.

The data demonstrate striking differences between hypothyroidism and hyperthyroidism. The elevated serum magnesium values and the lowered urinary excretion of magnesium in hypothyroids contrast sharply with their decreased exchangeable magnesium values. The data suggest that magnesium transport difficulties occur in thyroid hormone deficiency states.

STENOSIS OF RENAL ARTERY. — The frequency, severity, and location of renal arterial stenosis, in both the extrarenal and intrarenal arteries, have been determined in 154 patients comprising an unselected hospital necropsy sample, using the techniques of injection, serial section, and clearing. Severe renal stenosis was found to be bilateral in approximately half of the patients. Intrarenal stenosis of a severe grade was much more common in women than in men, and in the presence of severe extrarenal stenosis and girls aged 5-14 years have a slightly decreasing death rate, averaging about 7 per million. The rate for persons aged 15-64 has increased from about 7 per million in 1955 to about 9 in 1962. In persons 65 years old and over the overall rate has risen slightly to about 80 per million, the increase being more pronounced among women than among men. Deaths from scalds account for about one-tenth of the number due to burns, and have tended to decrease in all age-groups. The main change in mortality has therefore been an increase of deaths in persons aged 15-64. In spite of all efforts at prevention, total deaths per annum have increased slightly, though this increase is not marked when corrected for increase of population. — C. J. Schwartz, M. D., and T. A. White, M. B.: *British Medical Journal,* 2:1415-1421, December 5, 1964.

Predicting Severity of Erythroblastosis

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WARREN E. WHEELER, M.D., WILLIAM E. COPELAND, M.D., and WILLIAM C. RIGSBY, M.D.

THERE have been many attempts to analyze the value of serial Rh antibody titers in predicting the outcome of a particular gestation.[1-7] Most of these have been retrospective studies. Some have combined retrospective with prospective studies, but in these the prospective portion has been done without a control series, hence serious doubt remains about the value of titers when used to predict the need for preterm induction. Such was the case at our institution. It was impossible to establish a controlled prospective study because of the widespread conviction that preterm induction was valuable as a means of reducing severity of disease and that the titers could be used in predicting severity. One factor complicating the use of titers in predicting the outcome of a given pregnancy is the technical difficulty of obtaining reproducible results. Titers in various laboratories are seldom comparable, making extrapolation from one institution to another difficult. Moreover, Vaughan has pointed out that within each laboratory there exists an error from one determination to another unless all specimens are frozen and determined at one time using the same red cell population.[8]

Because of these facts we felt that more factual knowledge was essential before the value of serial titers could be assessed.

We planned the following study. The maternal history of a given pregnancy was presented to a clinician who was asked to predict the outcome and recommend whether preterm induction was necessary. The serologist gave similar predictions based on the serial titers. By this technique we hoped to simulate a prospective study, thus obtaining a more objective evaluation of the significance of titers versus a control (history).

Materials and Method

We reviewed the charts of all Rh negative women with detectable anti-Rh titers delivered at The Ohio State University Hospital during the years 1958-1962. The respective serial titers were also reviewed. The information regarding the maternal history was placed on one set of cards, the serial titers on a separate set of cards. All cards were identified by code number only. The cards with the past maternal and previous infant histories, henceforth termed history cards, were circulated individually to two experienced pediatricians and two obstetricians who had a particular interest in this problem. These four clinicians were asked to predict, if possible, the outcome of the current pregnancy and whether preterm induction was indicated. The serologist was given the cards with titers only and was requested to make similar predictions.

The second phase of the study was to determine the prognostic ability of physicians given both histories and titers. This information was supplied, again on an individual basis, to the serologist and to one of the pediatricians. These men did not have their previous predictions available to them. There was a total of 124 cases but four of these were not evaluated by the serologist because of insufficient data.

For purposes of analysis (see results) the predictions of all the physicians were divided into four groups. The first group, referred to as the pediatricians, consisted of the best predictions of both pediatricians grouped together. The second, called the obstetricians, represented the best recommendations of the two obstetricians. The third set represented the serologist's predictions alone. The

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*Clinical Cancer Trainee CST-071.
Submitted May 24, 1965.

fourth and last group consisted of the best predictions of the physicians who had both history and titer available. One must keep in mind, however, that all predictions were done on an individual basis, even though the results are in places pooled.

The actual predictions were compared to the outcome of the pregnancy in question, and, depending on the condition of the fetus at delivery and subsequent behavior of the infant, an evaluation was made (see tables). There were five possible choices that could be differentiated:

(1) Cases that could not be objectively analyzed because of inadequate data.

(2) Preterm induction recommended, which appeared to be correct in view of the condition of the fetus.

(3) Term delivery recommended, which appeared to be correct in view of the fate of the fetus.

(4) Preterm induction recommended, which appeared to be incorrect.

(5) Term delivery recommended, which appeared incorrect in view of the outcome. (In other words, in this group the infant really required preterm induction, e. g., was a stillbirth or severely affected infant.)

Any stillbirth or death due to hydrops or severe erythroblastosis fetalis was considered as a case in which preterm induction was indicated. Any infant born with a hemoglobin level of less than 11 Gm. per 100 ml.[10] was considered severely affected and could have been helped in the judgment of some by preterm induction.[11]

Serial titers were determined by four techniques (1) saline, (2) albumin, (3) indirect antiglobulin, and (4) enzyme.[9] Determinations were obtained on three or more occasions in most of the cases evaluated. The interval between determinations varied; however, in the majority of cases they were drawn between the 28th and 37th weeks of gestation.

Criteria Used by Serologist

(1) It is not possible to identify an Rh-negative fetus with certainty.

(2) Titer changes are most helpful in first sensitized pregnancies.

(3) A dramatic rise in titers is most often seen in a first affected infant.

(4) A "dissociated" rise (rising saline and/or albumin titer with level enzyme and Coombs titers) indicates an affected fetus.

(5) A "plateau" effect (no change in titer throughout pregnancy) is usually seen in women who have had two or more affected infants.

Results

In analyzing the data it was found that the different disciplines, i. e., pediatrics, obstetrics, and history plus titer group revealed remarkable consistency within each group. With regard to the stillbirth infants, there was only one disagreement in prediction between the two pediatricians. The same was true for the obstetricians. Therefore, we felt justified in pooling the correct predictions for each group. The physicians with both history and titers agreed with their predictions in the stillbirth group.

Therefore, all groups were treated in the same fashion. The correct predictions within each group were totaled, and it is these figures that are entered in the tables.

The tables show that titers alone were of no help in making a positive prediction whether or not to induce the pregnant mother to prevent stillbirth. The pediatric clinicians (Table I) using the past maternal

PEDIATRIC CLINICIANS' PREDICTIONS

124 CASES (TABLE I)

	TOTAL NO. IN EACH GROUP	CORRECT		INCORRECT	
		INDUCTION RECOMMENDED	TERM DELIVERY RECOMMENDED	INDUCTION RECOMMENDED	TERM DELIVERY (SEVERE ERYTHROBLASTOTIC INFANTS OR STILLBIRTHS)
STILLBIRTHS	10	6			4
Rh NEGATIVE INFANT	5		5		
MILD ERYTHROBLASTOSIS	2		2		
VARIABLE IN SEVERITY	16	0	11	1	4
NO PREDICTIONS OR EVALUATION POSSIBLE	91				
TOTAL CASES EVALUATED	33	→ 6	18	1	→ 8

TERM CORRECT AND INCORRECT REFERS TO THE IDEAL MANAGEMENT OF THAT PARTICULAR PREGNANCY IN VIEW OF THE ACTUAL FATE OF THE FETUS.

history, namely the fact that there were one or more previous stillbirths or severely affected erythroblastotic infants, as a guideline were able to recommend preterm induction correctly in six out of ten cases of stillbirths. The obstetrics clinicians (Table II)

OBSTETRIC CLINICIANS

124 CASES (TABLE II)

	TOTAL NO. IN EACH GROUP	CORRECT		INCORRECT	
		INDUCTION RECOMMENDED	TERM DELIVERY RECOMMENDED	INDUCTION RECOMMENDED	TERM DELIVERY (SEVERE ERYTHROBLASTOTIC INFANTS OR STILLBIRTHS)
STILLBIRTHS	10	5			5
Rh NEGATIVE INFANT	5		3	2	
MILD ERYTHROBLASTOSIS	2			2	
VARIABLE IN SEVERITY	16		7	5	4
NO PREDICTIONS OR EVALUATION POSSIBLE	91				
TOTAL CASES EVALUATED	33	→ 5	10	9	→ 9

TERM CORRECT AND INCORRECT REFERS TO THE IDEAL MANAGEMENT OF THAT PARTICULAR PREGNANCY IN VIEW OF THE ACTUAL FATE OF THE FETUS.

were able to predict correctly in five of ten cases. The clinicians had four additional stillbirths to evaluate because there were insufficient titers in four which voided any prediction by the serologist (Table III).

Of the five Rh negative infants, the obstetricians

SEROLOGIST'S PREDICTIONS

120 CASES (TABLE III)

	TOTAL NO IN EACH GROUP	CORRECT		INCORRECT	
		INDUCTION RECOMMENDED	TERM DELIVERY RECOMMENDED	INDUCTION RECOMMENDED	TERM DELIVERY (SEVERE ERYTHRO-BLASTOTIC INFANTS OR STILLBIRTHS)
STILLBIRTHS	6				6
Rh NEGATIVE INFANT	5		5		
MILD ERYTHRO-BLASTOSIS	2		2		
VARIABLE IN SEVERITY	16		12		4
NO PREDICTIONS OR EVALUATION POSSIBLE	87				
TOTAL CASES EVALUATED	29	→ 0	19		→ 10

TERM CORRECT AND INCORRECT REFERS TO THE IDEAL MANAGEMENT OF THAT PARTICULAR PREGNANCY IN VIEW OF THE ACTUAL FATE OF THE FETUS

recommended that two be delivered early. The two pediatricians and serologist did not recommend preterm induction in any of these.

The one infant in the entire 124 cases, who was actually born at 38 weeks gestation after induction and who died of respiratory distress but on autopsy had signs of mild erythroblastosis, would have been delivered early by the obstetricians and the two physicians having both history and titer available (Table IV). A second mildly affected infant would have been delivered preterm by the obstetric group.

The last group contained 34 infants who were affected but to a variable degree; however, 18 of

HISTORY AND TITER PREDICTIONS

120 CASES (TABLE IV)

	TOTAL NO IN EACH GROUP	CORRECT		INCORRECT	
		INDUCTION RECOMMENDED	TERM DELIVERY RECOMMENDED	INDUCTION RECOMMENDED	TERM DELIVERY (SEVERE ERYTHRO-BLASTOTIC INFANTS OR STILLBIRTHS)
STILLBIRTHS	6	2			4
Rh NEGATIVE INFANT	5		5		
MILD ERYTHRO-BLASTOSIS	2		1	1	
VARIABLE IN SEVERITY	16	3	6	6	1
NO PREDICTIONS OR EVALUATION POSSIBLE	87				
TOTAL CASES EVALUATED	29	→ 5	12	7	→ 5

TERM CORRECT AND INCORRECT REFERS TO THE IDEAL MANAGEMENT OF THAT PARTICULAR PREGNANCY IN VIEW OF THE ACTUAL FATE OF THE FETUS

these infants were delivered early making it impossible to evaluate whether those who recommended induction were correct or those who advised term delivery. The suggestive evidence of Kelsall and Vos[11] led some people to believe that early induction not only prevented stillbirth but would also decrease the requirement for exchange transfusions and the possibility of anemia. This meant that we could not evaluate that group of infants with objectivity. Therefore, we were left with 16 infants who were actually fullterm but were controversial as far as predictions were concerned. In this group, there were four infants who had hemoglobins below 11 Gm. per 100 ml. and required two or more exchanges. The only physicians to select three of these four severely affected infants out of 120 cases were the ones who had both history and titers available. The pediatricians, obstetricians, and serologist were unable to detect these three severe erythroblastotic infants. Two of these three infants were first affected, the third was the second affected infant. (Total of four severely affected) (Table V).

SUMMARY OF PREDICTIONS

(TABLE V)

	TOTAL NO. IN EACH GROUP	CORRECT INDUCTIONS	INCORRECT INDUCTIONS	INCORRECT TERM DELIVERY (SEVERELY AFFECTED INFANTS OR STILLBIRTHS
PEDIATRICIANS	29	4	1	6
OBSTETRICIANS	29	3	9	7
SEROLOGIST	29	0	0	10
HISTORY & TITER	29	5	7	5

SUMMARY OF PREDICTIONS OF ALL GROUPS BASED ON THE 29 CASES THAT ALL GROUPS COULD ADEQUATELY EVALUATE (FOUR STILLBIRTHS HAD INSUFFICIENT PRENATAL TITERS PERFORMED)

Comment

It is readily apparent that the serologist's opinion that titers in subsequently affected infants are less reliable, is borne out by this objective study. The titers were of no help in the group of stillbirths, 50 per cent of which had a preceding history, and certainly cannot distinguish Rh negative or mildly affected infants with any prognostic certainty.

However, the titers and history together enabled the physicians to predict that three would be relatively severe erythroblastotic infants and two of these three were *first affected* infants. It is also true that the titers and history led to one recommendation of preterm induction in a baby with mild erythroblastosis who died of respiratory distress. The results also bear out Chown's[1] opinion that titers are of help only infrequently, but on occasion they enable one to ascertain that a certain infant may be severely erythroblastotic.

It is important to point out at this time the relative accuracy of predictions for each group. If one takes into account that there were four additional severely affected infants which were missed by all groups because of insufficient information and adds this to the number of wrong predictions for each group, one can obtain an idea of the percentage accuracy expected by the different methods.

The pediatricians were accurate in 90 per cent of the cases, the obstetricians 83 per cent, the serologist 90 per cent and the history and titer group 87 per cent. Immediately, one is struck by the high degree of accuracy using history alone. However, one also must note the accuracy obtained by the serologist alone (Table III).

This occurred in this series because there were very

few stillbirths and severely affected infants; therefore, if one does not attempt to recommend preterm induction in any of the cases one will still be quite accurate in terms of percentage of total number of infants. The serologist using titers alone did not make any positive recommendations.

The implication is that there is a large number of erythroblastotic infants who are not severely affected or stillborn and, therefore, most of the infants will do well. However, in those few cases in our series in which accurate predictions were necessary the titers were of *no help*. In fact, in terms of accuracy, the combination of history and titers was less so than the control group (pediatricians). This difference is probably not significant; however, the point is that the combination of history and titers was not of any greater value than history alone except in regard to the three severely affected infants already discussed.

It becomes readily apparent that we should not express accuracy of predictions, when dealing with erythroblastosis, on the basis of the total number of infants at risk but rather in terms of stillborn and severely affected infants. It would be much more meaningful if one would relate one's stillbirth rate and one's error in prediction. By the latter we mean the number of times that one recommends preterm induction improperly and obtains an Rh negative or mildly affected infant.

Walker's[12] figures indicate that about 36 per cent of all stillbirths are preceded by a pregnancy which itself led to a stillbirth or a very severely affected infant. He also states that 70 to 80 per cent of all subsequently affected infants will be stillbirths[12] if preceded by a stillbirth. This means that any method introduced to aid in prediction of stillbirths would have its greatest value in the stillbirths whose mothers have not had any prior stillborns. Therefore, one should preferably express the value of any predictive method in terms of the number of stillbirths in those mothers who have never had a previous severely affected infant or stillbirth. This is similar to the way that Tovey and Valaes[4] express their results.

In addition, one should indicate the number of recommendations for preterm induction in which the infant was Rh negative or mildly affected. This would immediately give the reader an idea of the specificity of the technique.

If one assumes that the pediatricians in the first part of our study represent the control group that is recommending preterm induction only when the history so indicates, i. e., previous stillbirth or severely affected infant; then since their accuracy was over 90 per cent it is readily apparent that any method with an initially impressive accuracy of approximately 90 per cent does not in fact enhance one's prognostic ability. In order to appreciate a technique one must relate it to the stillbirth rate as well as the stillbirth rate in those mothers with first affected infants. One must also indicate the specificity by reporting the number of recommendations for early induction which led to mildly affected or Rh negative infants.

Summary

A retrospective controlled study of the relative prognostic value of anti-Rh titers and history was performed. The charts from the years 1958-1962 (124 cases) were reviewed, the histories placed on coded cards and the respective titers on separate coded cards. The coded histories were given individually to two pediatricians and two obstetricians. The titers were given to the serologist. The history and titers were later given to the serologist and one pediatrician separately with no information on their previous predictions. All participants were asked to predict the outcome of the fetus and recommend preterm induction. The predictions were then compared to the actual outcome of the fetus.

The results show that the pediatricians predicted accurately in 90 per cent of the cases, the obstetricians in 83 per cent, the serologist in 90 per cent, and the history and titer group in 87 per cent. These results indicate that the prognostic value of a technique should realistically be related to the stillbirth rate and to the number of times the recommendation for preterm induction was incorrect, i. e., the frequency of recommending preterm induction in a baby who is Rh negative or very mildly affected. The widely accepted method of expressing accuracy of prediction in terms of percentage of total number of erythroblastotic infants at risk is shown to be misleading and actually uninformative.

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What About Nose Drops in Kids?

Controlled Study of Xylometazoline*— A New Nasal Decongestant

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AMONG the most frequent complaints any physician dealing with children hears is that of a "stuffy nose." There have been moments when we have wondered whether the nose drops we were recommending in children were worth the effort or even accomplishing their purpose. The difficulty in objectively evaluating nose drops is obvious. Therefore we tried to determine if nose drops help little people; and if so, which kind are best.

Consequently an actual "double blind" procedure was set up comparing one of the most widely used decongestants, phenylephrine** with a newer preparation, xylometazoline. The plan, we felt, would serve a dual purpose. It would give us a comparison of this newer agent and an older preparation and would serve to elaborate whether or not the preparations actually helped the patient.

Phenylephrine, because of its wide use, requires no further description; there is no more "standard" medication used today. The newer xylometazoline belongs to a group of highly effective aromatic imidazoline derivatives of which Privine® is the most widely known. Xylometazoline is purported to be a pharmacologically structured improvement over this best known of vasoconstrictors.

Clinical reports[1-4] have indicated the compound closely approaches the concept of the ideal topical vasoconstrictor — effective, longer duration of action, fewer radical side effects, and with little or none of the usual rebound phenomena.

Plan of Study

Our plan of study, therefore, served a dual purpose. One was to determine whether nose drops were worth the effort and the other was to evaluate which of the preparations was the best for the purpose.

We chose phenylephrine 1/4 per cent as our standard of control, because it is a preparation in wide use whose qualities, advantages, and limitations are well known. The other compound, xylometazoline 0.05 per cent, was chosen because it had seemed to be very efficacious in practice and was well accepted. The initial clinical reports were also impressive.

Patients were randomly selected. Since we considered the nose and upper respiratory passages as our major concern, our only criterion for selection was a "stuffy nose," regardless of whether it was related to a "cold" or pneumonia; simple "URI" or complicated otitis media. We felt that such related conditions might well be left for some future more detailed tangential analysis or study.

Both preparations were prepared for our study by the manufacturer of the newer compound. The drugs were then placed in identical, unmarked, plain, coded bottles. After selection, patients were given the plain bottle of medication with a printed instruction sheet and report form. They were requested to follow instructions carefully, record their observations, and return within 48 to 72 hours. Upon their return, parents were queried as to whether: (1) the drops helped, (2) the child objected and how much, (3) the effects were evident and how soon, (4) the effect lasted and how long, and (5) there were any untoward reactions. The code was not broken until the first group had been completed and had returned their reports.

Results

By chance, of the first group of 44 patients, 22 received xylometazoline and 22 received phenylephrine.

Tables 1 and 2 depict age distribution, action, etc.

Conclusions

In our study, and as can be noted from Tables 1 and 2, both preparations were equally effective, helpful, and acceptable with but one major interesting

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*xylometazoline hydrochlorothiazide (Otrivin®) CIBA.

**phenylephrine (Neo-Synephrine®).

TABLE 1. *Xylometazoline (22 patients) 0.05%*

Age	0 - 1	2 - 3	4	5
No. of Patients	10	8	3	1

Help	No	Yes
No. of Patients	2	20

Acceptance	Good	Fair	Poor
No. of Patients	14	3	5

Onset of Action (minutes)	0 - 5	5 - 10	10 - 15	15 - 30
No. of Patients	12	2	5	3

Duration (Hours)	0 - 1	1 - 3	3 - 4	4 - 6	6 - 8	8
No. of Patients	2	2	6	5	6	1

TABLE 2. *Phenylephrine (22 patients) 0.25%*

Age	0 - 1	2 - 3	4	5
No. of Patients	9	7	3	3

Help	No	Yes
No. of Patients	4	18

Acceptance	Good	Fair	Poor
No. of Patients	11	8	3

Onset of Action (minutes)	0 - 5	5 - 10	10 - 15	15 - 30
No. of Patients	11	4	3	4

Duration (Hours)	0 - 1	1 - 3	3 - 4	4 - 6	6 - 8	8
No. of Patients	5	9	5	2	1	0

difference. Although onset of action was fairly similar, xylometazoline presented a far more favorable duration of effect. Duration of action lasted three to eight hours in over 82 per cent of the patients who received xylometazoline, whereas 64 per cent of the patients receiving phenylephrine had a duration of effect of three hours or less. Further, phenylephrine was ineffective in 23 per cent, and 41 per cent showed only one to three hours duration.

The two patients who found xylometazoline ineffective were children who did not like nose drops and did not accept the situation with any degree of cooperation. There were no side effects of consequence noted with either preparation.

It was interesting in that one particular instance, a physician's set of infant twins (3 months) suffering from nasal stuffiness were treated for three days with one coded bottle and then switched to the other bottle. One bottle was recorded as having given "better, more complete relief of stuffiness and longer duration of action." When the code was broken the bottle giving greater, more prolonged relief proved to be xylometazoline.

It is our opinion that the newer nasal vasoconstrictor, xylometazoline, is apparently as effective as one of the most widely used preparations, phenylephrine, in children with nasal congestion. This new compound, which has an added important factor of offering a very significantly longer duration of action, deserves further study. In the interim, it can be used safely and effectively as a nasal decongestant in infants and children.

Summary

A double blind comparative study of two nasal decongestant preparations was made in 44 randomly selected children with nasal stuffiness. The study revealed that the newer preparation (xylometazoline) was as effective as an older, widely used compound with one important difference. The more recent compound presented a much longer duration of effect in the vast majority of cases. Further use, study and evaluation is recommended.

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A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

COLIN R. MACPHERSON, M. D., *President*

PRESENTATION OF CASE

A NEGRO WOMAN, aged 40, was admitted to University Hospital with the chief complaint of vaginal bleeding and fatigue. She had been well until three months prior to admission when a spontaneous abortion occurred at three months. She was hospitalized and a dilatation and curettage was performed. She was told at this time that her blood pressure was elevated but not high enough to require medication. Following surgery she bled for approximately six weeks, using six to eight pads per day, then stopped bleeding without treatment. Throughout this period she felt some malaise and weakness. Her fatigue persisted and she went to her family physician. He told her that her blood pressure was still elevated but prescribed no medication. She did not improve and became somewhat dyspneic on exertion.

About three weeks prior to admission she again had vaginal bleeding as before. Two weeks prior to admission a throbbing, generalized headache began that usually started in the occipital area, was more severe when she arose in the morning, and would gradually subside during the day. She experienced some nausea but vomited very little. One week prior to admission she developed sudden back pain, which persisted. She had dysuria and urinated less frequently and in small amounts. She began to vomit more frequently and ate less well. She complained of blurring of vision and of diplopia. Her symptoms increased and a few days prior to admission she vomited each time she attempted to eat. The patient sought hospitalization and at her local hospital her blood pressure was elevated and her blood urea nitrogen was 175 mg., her creatinine 22 mg./100 ml. Her hemoglobin was 6.5 Gm. Transfusion with 1½ units of whole blood was performed and she was transferred to University Hospital.

At the time of her first pregnancy (twins) 12 years before this, she was told that her blood pressure was high and that she should not become pregnant again. She apparently did well without treatment and subsequently had four more children and the only complication was puffiness of her face with her second pregnancy. At no time with her subsequent pregnancies was she told that her blood pressure was out of the range of normal. She denied any symptoms of urinary tract infection, kidney ailments, cardiorespiratory difficulties or significant gastrointestinal complaints in the past. Her father died of hypertension and a kidney disease of unknown etiology, and a sister and brother had hypertension.

Submitted November 22, 1965.

Presented by

- **William H. Carter, M. D., Columbus, and**
- **Dante G. Scarpelli, M. D., Ph. D., Columbus.**

Edited by Dr. Scarpelli.

Physical Examination

The patient was well developed, slightly obese, rather lethargic and answered questions with some difficulty. She appeared acutely ill and showed some puffiness of her hands and about her eyes. Her blood pressure was 230/120, her pulse rate 104 per minute and regular, respiratory rate 24/min., the temperature normal. The pupils reacted normally. Both fundi showed fresh hemorrhages and exudates and approximately 2 diopters of papilledema; the arterioles were narrowed and Grade I-II arteriosclerotic changes were reported. The neck veins were somewhat distended and filled from below when the patient was tilted up about 10°. There were moist rales at both lung bases but no dullness was noted.

The heart had a sinus tachycardia with the point of maximum impulse located 2 cm. to the left of the midclavicular line in the fifth intercostal space. A loud presystolic gallop was heard and no murmur. The abdomen was slightly distended. The liver was palpable 8 cm. below the right costal margin and was not irregular or tender. There was no splenomegaly. The bowel sounds were normal. There was 1 plus pretibial and pedal edema. The pedal pulses were present. The neurological examination was nor-

mal except for papilledema and lethargy. A pelvic examination revealed uterine bleeding and an otherwise normal pelvis.

Laboratory Data

On admission the hemoglobin was 6.7 Gm., the hematocrit 23 per cent; leukocyte count 11,400 with a normal differential count; there was moderate hypochromia of the red blood cells with occasional macrocytes. The 5 ml. of urine that was obtained for initial examination was cloudy, had a specific gravity of 1.018, contained 1,920 mg. of protein per 100 ml., no sugar or acetone, 3 to 4 white blood cells, 20 to 30 red blood cells, and a few epithelial cells per high power field. The CO_2 combining power was 17, sodium 133, potassium 5.9, and chloride 100 mEq./L. The blood urea nitrogen was 191, the uric acid 12.4, and the creatinine 30 mg./100 ml. The total protein was 5.4 Gm./100 ml. with 4 Gm. of albumin and 1.4 Gm. of globulin. The fasting blood sugar, serology, and vaginal Papanicolaou smear were within normal limits.

X-ray of the chest showed evidence of passive pulmonary congestion. Supine and right decubitus films of the abdomen gave the appearance of ascites fluid. There were also areas of radiolucency along the left upper side of the abdomen that suggested free air.

Hospital Course

Shortly after admission paracentesis was performed but no fluid was obtained. On cystoscopy, both ureters were easily catheterized and a few drops of urine were obtained from the left kidney but none from the right. A retrograde pyelogram suggested atrophy of the right kidney; the left pyelogram appeared normal. There was no evidence of obstruction. A Foley catheter was then left in place. The patient had a urine output of only 40 cc. on the first hospital day. She was given digoxin, fluids were restricted, and she was given reserpine intramuscularly. A peritoneal dialysis was started on her second hospital day. She tolerated this well, and the following day her blood urea nitrogen fell to 91 mg. and her creatinine to 17.2 mg. She was given packed red cells. She became more alert and responded more readily to questions.

Throughout the hospital course the patient had guaiac-positive stools. Her urinary output remained less than 100 cc. each day. With intravenous fluids and intravenous Apresoline® her diastolic pressure was maintained at about 100 mm. Hg. Her blood urea nitrogen and creatinine again rose slowly after the dialysis, her urea nitrogen reaching 214 mg. on the fifteenth hospital day. A steadily rising potassium was controlled to some extent with a potassium exchange resin. The patient's lungs remained relatively clear. She was on a 20 Gm. protein diet with 20 mEq. potassium. She later developed slight swelling and tenderness in the area of the cut-down on her foot. She became progressively comatose, and her potassium rose to 8.9 mEq. She had 2 units of packed red cells during the hospitalization. The hemoglobin remained at about 7.5 Gm. until the last three hospital days, when it fell to 4.4 Gm.

On her sixteenth hospital day the patient developed hypotension and an arrhythmia and died shortly thereafter.

CLINICAL DISCUSSION

DR. CARTER: I am going to approach what I think really happened to this woman from two aspects. This has to do with relating this to her pregnancies and to the last pregnancy, which terminated with a spontaneous abortion. We are told that at the time of her first pregnancy, when she was about age 28, she was noted to have elevation of blood pressure. We know nothing else — whether she manifested other symptoms of toxemia or not — but we know that we are dealing with a 28 year old woman who had elevation of blood pressure in pregnancy. We can only speculate as to whether hypertension existed prior to that time or not. There is nothing, I think, that answers the question for us at that point. She was neither a young nor an old primpara and thus was in the middle ground as far as being the type of patient in whom we would expect to see toxemia of pregnancy occur. We do know that she apparently tolerated four subsequent pregnancies without significant difficulty. At age 40 she became pregnant again and this seemed to set off her terminal illness leading to death in renal failure with severe hypertension.

Pregnancy and Renal Function

What kinds of things happen during pregnancy that might present this picture? One of the interesting things that happens initially upon gestation is the elaboration of humoral or hormonal-like substances apparently from the placenta that have a tremendous stimulatory effect on renal function. Long before anything has happened that you can detect as pregnancy by the usual manifestations, by the fourth to eighth week, the glomerular filtration rate has risen to 150 per cent or higher of what it is in the normal nonpregnant state. This gradually diminishes towards term and somewhere from two to six weeks postpartum it will return to normal. In the presence of preëxisting renal disease, which I suspect this patient may have had, instantaneously with conception renal function begins to deteriorate. We can relate this with what happens to renal plasma flow.

We see the same type of percentage increase in renal plasma flow associated with the very early stages of pregnancy, and we see a deterioration of renal plasma flow in the face of preëxisting renal disease in pregnancy. This is analogous, after a fashion, to what one can do experimentally. If for any reason we compromise the kidney by interfering with

the vascular supply or by wrapping it in cellophane, we can produce an ischemic situation if we give exogenous growth hormone. This is quite similar to what we see in pregnancy and in kidney disease — the elaboration of some substance that stimulates the kidney to hypertrophy and increases its function, and if these are impaired the result is a severe degree of hypertension. Whether eclampsia in itself leads to chronic kidney disease and hypertension sometime in the future remains unanswered.

There are two schools of thought on this. The late Dr. Dieckmann believed that eclampsia itself never led to permanent kidney disease or to permanent hypertension. On the other hand, another obstetrician, Dr. Elliott Page, feels quite strongly that hypertension and chronic kidney disease may be a sequel to eclampsia — the idiopathic eclampsia of pregnancy. Another possibility comes to mind at the very mention that this woman at the age of 40 became pregnant again: If she had some form of underlying chronic kidney disease prior to this time, she could demonstrate this accelerated form, which in a sense is a toxemia of pregnancy superimposed upon preëxisting renal disease, leading to renal failure and severe hypertension.

Some things we are told about the x-rays are somewhat bothersome. I cannot explain the presence of the free air in the abdomen that is described in the decubitus film unless the film might have been taken after the patient had had an abdominal tap. There is nothing in the information we are given that would lead me to think that she had a perforated viscus or anything that would be associated with free air within the abdominal cavity.

Atrophic Kidney

The other thing with regard to her x-rays that I would like to bring up before we look at them is this apparent discrepancy in renal size that we are told existed on the retrograde pyelogram. This becomes extremely interesting to think about. We are told that she had a small or even atrophic right kidney but a left kidney that appeared to be normal, and one of the things we don't like to see is somebody dying of kidney disease who has one normal size kidney. This always bothers us to understand why this exists. One of the things we have come to recognize is that preëxisting renal vascular disease — that is, some form of stenotic disease involving one or both renal arteries — in the presence of pregnancy can mimic the toxemia of pregnancy, can mimic the full-blown picture of eclampsia. May we look at the x-rays and get this clear?

DR. DUNBAR: The abdominal x-ray shows a collection of gas that suggests mild intestinal ileus secdonary to abdominal ascities. The chest film shows the presence of subdiaphragmatic air bilaterally. I feel fairly certain that this film was taken after the paracentesis. The heart is at the upper limits of normal size, and there is a slight passive pulmonary hyperemia. There is a slightly large left ventricle and a slightly elongated aorta consistent with hypertension. The retrograde pyelogram shows an atrophic right kidney and a normal size left kidney.

DR. CARTER: We have learned in the last few years that we should be extremely concerned about the presence of renal vascular stenosis in any patient with hypertension who has discrepancy in kidney size. I think this becomes even more important when any history to suggest another cause for this discrepancy in size is absent. We are told that this woman never had had any problems of urinary tract symptomatology or infection. One of the things that we would certainly think about is the possibility of an atrophic pyelonephritis. I think that we might consider that this woman had a renal artery stenosis on the right side of a fibromuscular type and that the left kidney, having been subjected to persistent elevation of blood pressure, had undergone arteriolosclerosis secondary to the hypertension and had some atrophy on this basis.

Renal Artery Stenosis

One other thing that comes up appears early in her course: One week prior to her admission she experienced an episode of severe back pain which apparently persisted, and it was also noted at that time that there was a change in the volume of urine that she was making, and she remained in this state essentially throughout the rest of her course. What might have happened in this situation to account for her back pain and this rapid decrease in function? It is conceivable that with the nausea and vomiting and all that was present, perhaps some degree of dehydration, this woman may actually have thrombosed either all or part of the left renal artery and literally infarcted her kidney.

Another possibility that one has to consider in such a situation is this: We know that renal artery aneurysms can be associated with hypertension and we also know that these are predisposed to rupture. Conceivably, and I bring it up just to mention that such a thing does exist, a renal artery aneurysm as a cause of hypertension could be present in a situation like this and its rupture could account in part for the back pain that was present. The possibility that she may have infarcted the left kidney, which was perhaps carrying a large percentage if not all of her renal function at that time, is suggested in some way by the urinalysis that was obtained, which showed a large percentage of protein, although the volume was small, and the presence of red cells. This could all go along with infarction.

To summarize, two possibilities exist: (1) We are dealing with a woman who had toxemia of pregnancy at or around the age of 28. This was associated either with some preëxisting hypertension or in itself led to a hypertensive state with some degree

of kidney damage. This was progressive, untreated, and then with the additional insult of a pregnancy late in life that was complicated early in its course by toxemia, it went on to progressive renal failure. (2) The second consideration we would have is that this woman from the beginning had renal artery stenosis on the right side, with subsequent atrophy in the left kidney secondary to the hypertensive disease itself, and then finally perhaps had an infarction of all or part of the left kidney, went rapidly into renal failure and died.

DR. SCHIEVE: What is this disease that happens to the other kidney?

DR. CARTER: I think it is arteriolosclerosis. I am sure Dr. Scarpelli can explain this much better than I, but if you develop muscular hypertrophy and hyperplasia of the arterioles secondary to the hypertension, this leads to further renal ischemia that may eventuate in renal failure.

DR. SCHIEVE: I would like to ask you about the problem of pancreatitis in these patients. Is it present in the uremic syndrome alone or particularly in those patients who have had peritoneal dialysis?

DR. CARTER: I think if you had to pick a way to diagnose uremia in a patient it would be to look at the pancreas. I think that you almost invariably are going to see some pancreatic disease existing in the presence of uremia.

DR. SASLAW: Is the pancreas reachable with a needle or a trocar?

DR. CARTER: It would be reachable certainly, but heaven forbid that we get there with a trocar. I think it is possible that in peritoneal dialysis the tonicity of the fluids that we use may be sufficient to precipitate pancreatitis.

DR. SMITH: I would say that on the one occasion when we thought it was conceivable that peritoneal dialysis had created pancreatitis, straight 7 per cent dialysis solution had been used. We don't use that any more. We always dilute the 7 per cent dialysis fluid at least half by using 1.5 per cent dialysis fluid.

DR. SCHIEVE: Bill, in the diagnosis of fibromuscular hyperplasia of the renal arteries, I have been under the impression that it can only be made accurately on renal arteriography where you see the beaded appearance of the renal artery. Is this true? Or if you don't have this appearance, can you still implicate this diagnosis?

DR. CARTER: I think fibromuscular hyperplasia now really constitutes a group of five entities, one of which will give you the beaded appearance that you see radiologically. There are things that we can use to diagnose this — going on the basis of the location of the lesion. Almost invariably we look for fibromuscular hyperplasia in the distal third of the main renal artery or at the bifurcation involving the segmental arteries as opposed to atheromatous plaques, which are invariably at the orifice or within the proximal one third of the artery. I think that in general we do very well in picking out fibromuscular hyperplasia from renal artery atherosclerosis.

CLINICAL DIAGNOSIS

1. Hypertensive heart disease.
2. Right renal artery stenosis.
3. Renal hypertension.
4. Uremia.

PATHOLOGICAL DIAGNOSIS

1. Thrombosis of right renal artery.
2. Atrophy of right kidney.
3. Arteriolar and arterial nephrosclerosis.
4. Acute and chronic pyelonephritis.
5. Uremia.
6. Acute necrotizing pancreatitis.
7. Hypertensive heart disease.

DISCUSSION OF PATHOLOGY

DR. SCARPELLI: This is an extremely interesting case, which at autopsy showed ascites, pericardial effusion, and evidence of hypertensive heart disease. Her heart weighed 450 Gm. and the left ventricle measured 1.8 cm. in thickness. The lungs were slightly heavier than normal and microscopically showed an early uremic pneumonitis with its characteristic hemorrhage with fibrin. The pancreas was edematous and hemorrhagic. Microscopically, there was evidence of acinar cell injury and fat necrosis. This woman also had thickened arterioles in her pancreas and the hallmark of uremic pancreatitis, so-called, described first by Baggenstosse at the Mayo Clinic. What this amounts to is an inspissation of secretions within the acini and the ductular system of the pancreas. This characteristically does not lead to a hemorrhagic pancreatitis; however, in view of the several days of severe hypotension described in her clinical course, in the presence of severe arteriolar sclerosis, hemorrhagic necrosis may well have ensued.

The right kidney weighed 25 Gm. and was described as being atrophic. This was predicated on the normal size pelvis and calyceal system in the face of a truly diminutive kidney. The two renal arteries supplying this organ were probed and appeared to be completely occluded; however, microscopically there was evidence of recanalization of what was probably old thrombosis. The next problem, of course, was the contralateral kidney. It weighed 175 Gm., was edematous and showed the "flea-bitten" appearance that we not uncommonly see in malignant nephrosclerosis, or accelerated hypertension. The cortico-medullary junction was indistinct, and there were multiple petechial hemorrhages throughout the renal substance. The left renal artery was patent although it and its intraparenchymal branches were sclerotic.

The microscopic appearance of the two kidneys

was vastly different. The right kidney showed extensive atrophy as characterized by loss of interstitial tissue and marked crowding of glomeruli. The interstitium was infiltrated with both acute and chronic inflammatory cells, and although morphologically it appeared to be capable of little or no function, there was no evidence of necrosis. The arterioles were only moderately sclerotic. The tubules appeared atrophic and were filled with inspissated material. The renal artery was sclerotic and there was evidence of old thrombosis with organization and recanalization.

In the left kidney we again encountered extensive acute and chronic interstitial inflammation with several areas of abscess formation. Again, large numbers of tubules were probably not functioning very well. The glomeruli did not show the proliferative and membranous vascular lesions found in toxemia of pregnancy. So, although there was a strong possibility of this in this woman, it was not present. The parenchymal arterioles showed extensive sclerosis with intimal proliferation to a far more severe degree than that present in the right kidney.

The extensive interstitial infection present in this case is of interest inasmuch as there was no history whatever suggesting kidney infection. This emphasizes the point Dr. Kass is always making that kidney infection can exist in the asymptomatic patient.

This case has several noteworthy features which merit amplification and may well fit into a pattern of pathogenesis which eventuated in this woman's death. Twelve years ago, at the time of her first pregnancy, she already had an elevated blood pressure, which may have been of non-renal origin. Her history shows a strong family background of high blood pressure. Repeated pregnancies with their profound effects on renal function, especially the decreased excretion of sodium, may well have aided in intensifying her hypertension. The coup de grâce was delivered when the right renal artery became thrombosed. The resulting cortical ischemia resulted in the elaboration of vasopressor substances which further elevated the blood pressure. The diminution of blood flow secondary to the thrombosis in effect protected the arterioles of the right kidney from the ravages of hypertension, while those of the left kidney responded by extensive sclerosis. Thus the culprit organ is spared, precisely what was found here. The right renal atrophy not only removed effective functional renal mass but predisposed the organ to infection.

DR. GWINUP: Let me ask you whether you think that at one time in her life she had two normal kidneys.

DR. SCARPELLI: Yes, I think so; the size of the pelves and ureters would support this. In this hypoplastic kidney the size of the pelvis and ureter is in proportion to the rest of the kidney. In an acquired atrophy the ureter and pelvis are of normal size, while the kidney mass is small. Since these were the findings in this case, the right kidney was most probably atrophic.

Dr. Carter, what do you as a clinician think is the important factor or factors that determine whether or not a hypertensive patient is going to have a good result from removal of a kidney that is affected by unilateral vascular disease?

DR. CARTER: He is going to have a good effect if he does not have arteriolar disease in his opposite kidney. If he does have it there, then he should have a nephrectomy on that side and vascular repair of the contralateral kidney. If this is due to stenosis and there is a pressure gradient that is greater than 35 mm. of pressure, and if he has an increase in the number of granules in the juxtaglomerular apparatus on the side with stenosis, then I think you can probably predict a good result.

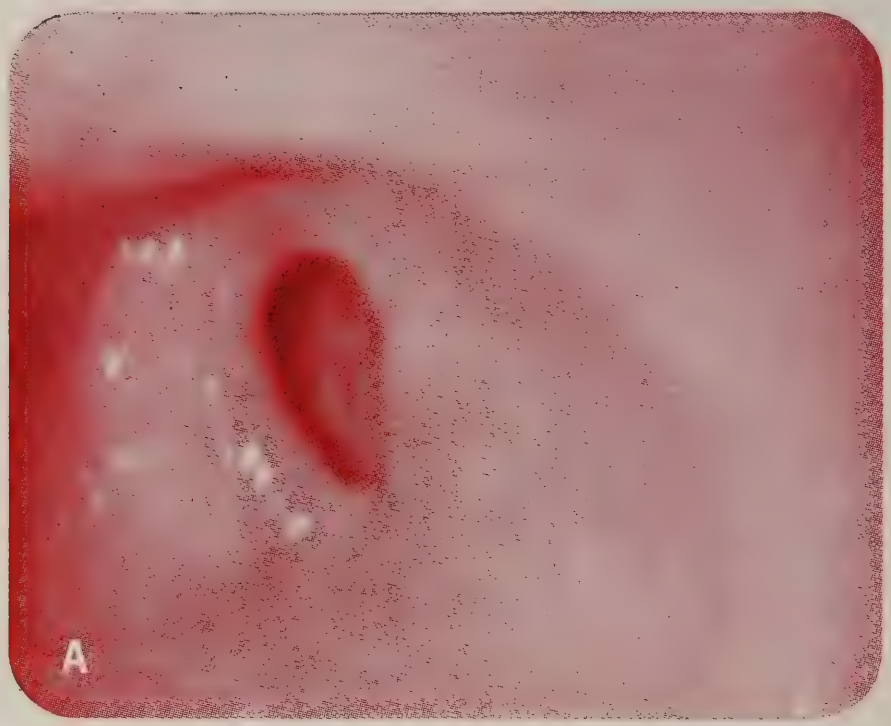
DR. SASLAW: Bill, doesn't duration of the hypertension play a part here too?

DR. CARTER: I don't think so.

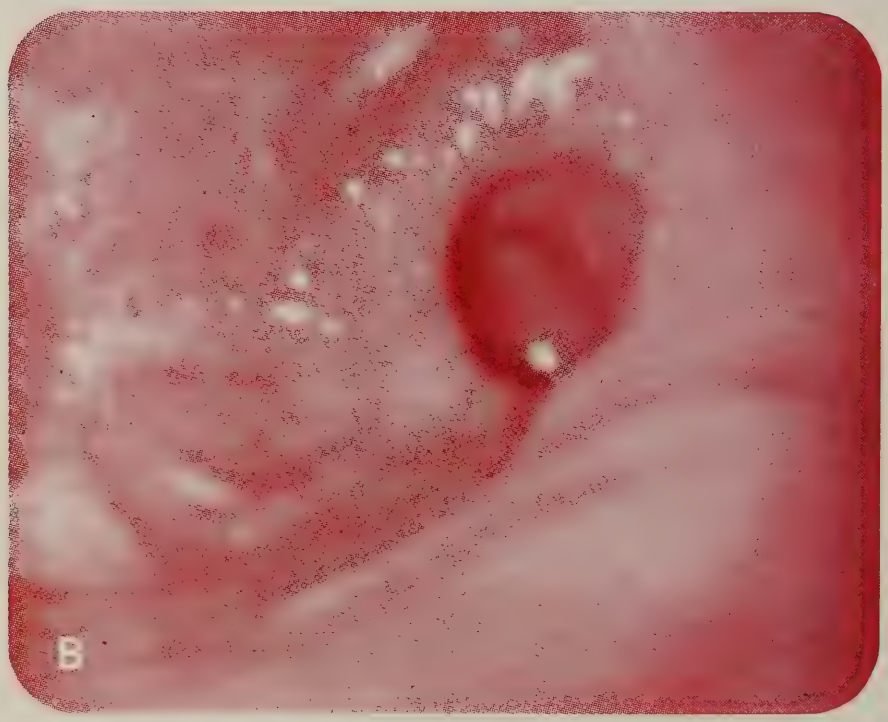
DR. SASLAW: In time doesn't it become irreversible?

DR. CARTER: It does become irreversible if you have reached the stage in which you have arteriolar changes in the contralateral kidney. But one person may get this in one month and the next one may not have it 15 years later.

DILEMMAS IN THE PRACTICE OF SURGERY. — The sum total of the experience of a mature surgeon, one who has systematically made a critical analysis of his acts, makes up a precious legacy that can be transmitted only partially to his successors. This experience gives him a moral dimension and shapes his individuality both personal and professional. It enables him to make a wise choice, in advance, of his operative technique and guides his hand in the process of the actual operation. Every year should find him an abler surgeon than the year before. — Achille Mario Dogliotti, Turin, Italy: *Bulletin of The New York Academy of Medicine,* 41:1107-1116, November, 1965.



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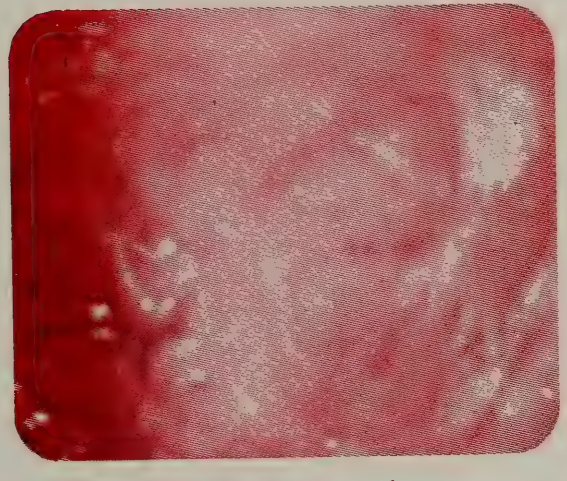
Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.

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Pro-Banthine, in minimal dosage, produces effects similar to pyloroplasty and vagotomy without the disadvantages of permanent post-vagotomy sequelae.

The intragastric photograph A is of a patient who has had pyloroplasty with vagotomy. Photograph B is of a patient given 6 mg. of Pro-Banthine.

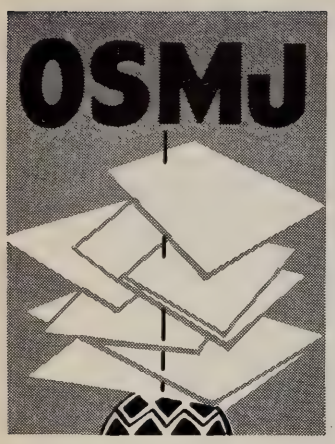
Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

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SEARLE

Research in the Service of Medicine



NEWS AND Organization Section

Proceedings of The Council ...

Minutes of December 11-12 Meeting; Approved 1966 Budget; Also Report of Other Matters Considered and Actions Taken

A REGULAR MEETING of The Council of the Ohio State Medical Association was held on December 11-12, 1965 at the Home Office Building of Ohio Medical Indemnity, Inc., 3770 North High Street, Columbus. All members of The Council were present except Dr. P. John Robechek, Cleveland, Councilor of the Fifth District. Others attending were: Mr. Wayne Stichter, Toledo, legal counsel; Dr. Perry R. Ayres, Columbus, Editor, *The Ohio State Medical Journal;* Dr. Charles L. Hudson, Cleveland, President-Elect of the AMA; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Dr. George W. Petznick, Cleveland, AMA delegate; Dr. John H. Budd, Cleveland, Chairman of the Ohio delegation to the AMA; Dr. Edmond K. Yantes, Wilmington, delegate to the American Medical Association and President, Ohio Medical Indemnity, Inc., Board of Directors; Mr. Charles H. Coghlan, Columbus, Executive Vice-President, Ohio Medical Indemnity, Inc.; Mr. Herman Tice, Tice & Company, Inc., Columbus; Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff.

Minutes Approved

The minutes of the meeting of The Council held on November 21, 1965 **were approved** by official action.

Membership Statistics

The following membership statistics were announced by Mr. Page: OSMA membership as of December 10, 1965, 10,040, compared to a total membership at the end of 1964 of 9,933. The report stated that of the 10,040 OSMA members, 9,010 were affiliated with the AMA.

Reports by Councilors

The Councilors reported on activities in their respective districts.

1966 Annual Meeting

Mr. Traphagan presented a progress report on the 1966 Annual Meeting. The Council decided to ask AMA President-Elect Charles L. Hudson to discuss the Medicare Act at a general session program on Thursday, May 26.

Reports on AMA Meetings

Dr. Budd reported on the special session of the American Medical Association House of Delegates in Chicago, October 2-3, and the clinical session held November 28 - December 1 in Philadelphia. By official action, The Council **commended** Dr. Budd for his leadership of the Ohio AMA Delegation at these meetings and **approved** the report.

Summaries of the special meeting in October appeared on pages 1019 through 1021 of the November, 1965, issue of *The Ohio State Medical Journal,* and the clinical session in Philadelphia on pages 58 through 60 of the January, 1966, issue of *The Journal.*

Mr. Page reported on plans for the presidential reception to be held by the Ohio delegation in connection with the inauguration of Dr. Charles L. Hudson, Cleveland, as President of the American Medical

Association, Tuesday, June 28, 1966, at the AMA Annual Meeting, Chicago.

Financial Report

The Council then went into executive session and a report of the Committee on Auditing and Appropriations was presented by the chairman, Dr. Robert E. Howard, Cincinnati. The report of the committee, including a budget for 1966, **was approved** by official action.

BUDGET FOR 1966

The Ohio State Medical Journal	$ 47,000.00
Organizational Staff Salaries and Expenses	62,500.00
Stenographic and Clerical Salaries	61,195.00
President: Expense $4,500; Honorarium $2,000	6,500.00
President-Elect: Expense $2,500; Honorarium $1,000	3,500.00
Council, Expense	7,500.00
American Medical Association Delegates and Alternates	20,000.00
Department of Public Relations ($34,325.00)	
Salaries and Expenses	19,825.00
Exhibits and Newspaper Publicity	500.00
Literature	500.00
Postage	3,000.00
Supplies	500.00
Miscellaneous Activities	10,000.00
Committees:	
Education	500.00
Judicial and Professional Relations	600.00
Public Relations and Economics	400.00
Scientific Work	1,000.00
Auditing and Appropriations; Bookkeeping	1,270.00
Cancer	150.00
Care of the Aging	600.00
Disaster Medical Care	600.00
Eye Care	300.00
Hospital Relations	2,000.00
Laboratory Medicine	500.00
Maternal Health	1,650.00
Medicine and Religion	300.00
Mental Health	1,200.00
Rural Health	1,800.00
School Health	1,500.00
Workmen's Compensation	500.00
Environmental and Public Health (Occupational Health, Poison Control, Radiation, Traffic Safety Committees combined into one committee.)	1,150.00
Annual Meeting	30,000.00
Conference of County Society Officers	2,500.00
Councilor District Conferences	4,500.00
Emergency and Equipment Fund	6,475.00
Employees' Retirement Fund	13,500.00
Insurance, Bonding, and Social Security	11,220.00
Lectures for Senior Medical Students	2,800.00
Legal Expense	12,000.00
Library	300.00
OSMAgram	7,500.00
Postage	2,800.00
Professional Relations Activities	6,500.00
Rent and Utilities	21,465.00
Rural Medical Scholarships	3,500.00
Stationery and Supplies	6,000.00
Telephone and Telegraph	6,100.00
Woman's Auxiliary Contribution	1,500.00
New Office in Huntington Building: Equipment and Moving Expense	15,000.00
Total	$412,200.00

OSMA Employees' Pension Plan

Following the executive session, The Council discussed with Mr. Herman Tice of Tice & Company, Inc., changes in the Ohio State Medical Association employees' pension plan as proposed by the Auditing and Appropriations Committee.

On **motion** duly made, seconded and **carried,** The Council voted:

That the present pension plan be amended as follows:

1. That there be adopted a formula of benefits to provide a retirement income equal to 45 per cent of monthly salary, including the primary social security benefit in effect as of December 17, 1965, based upon a straight life annuity income option with a minimum income provision of $100 per month from the OSMA pension plan.

2. We recommend that this increase in benefit be limited to those participants who as of December 17, 1965, are not over age 61, and to those who after December 17, 1965, are not over age 60.

3. That the Plan be changed in the method of funding from a fully insured basis to what is known as the combination method of funding and that the amount by which the contracts are overfunded at this date of conversion be applied against the deposits required over the next five years.

Ohio Medical Indemnity and Medicare

Dr. Yantes appeared before The Council to report that the Ohio Medical Indemnity Board of Directors had recommended on December 8, 1965 that OMI apply as a fiscal intermediary under Part B of the Medicare Act.

Mr. Coghlan reported that Blue Shield contracts for subscribers age 65 and over billed at home would continue.

An executive session of The Council was then held and the following **was adopted** on **motion** by Dr. Smith, seconded by Dr. Fulton:

"That the Board of Ohio Medical Indemnity be informed that The Council of the Ohio State Medical Association does not object to Ohio Medical Indemnity making application for appointment as a fiscal intermediary under Part B of the Medicare Act, provided, however, that if the application is granted and the government designates Ohio Medical Indemnity as such, Ohio Medical Indemnity will submit the proposed contract to the Ohio State Medical Association Council before entering into such contract."

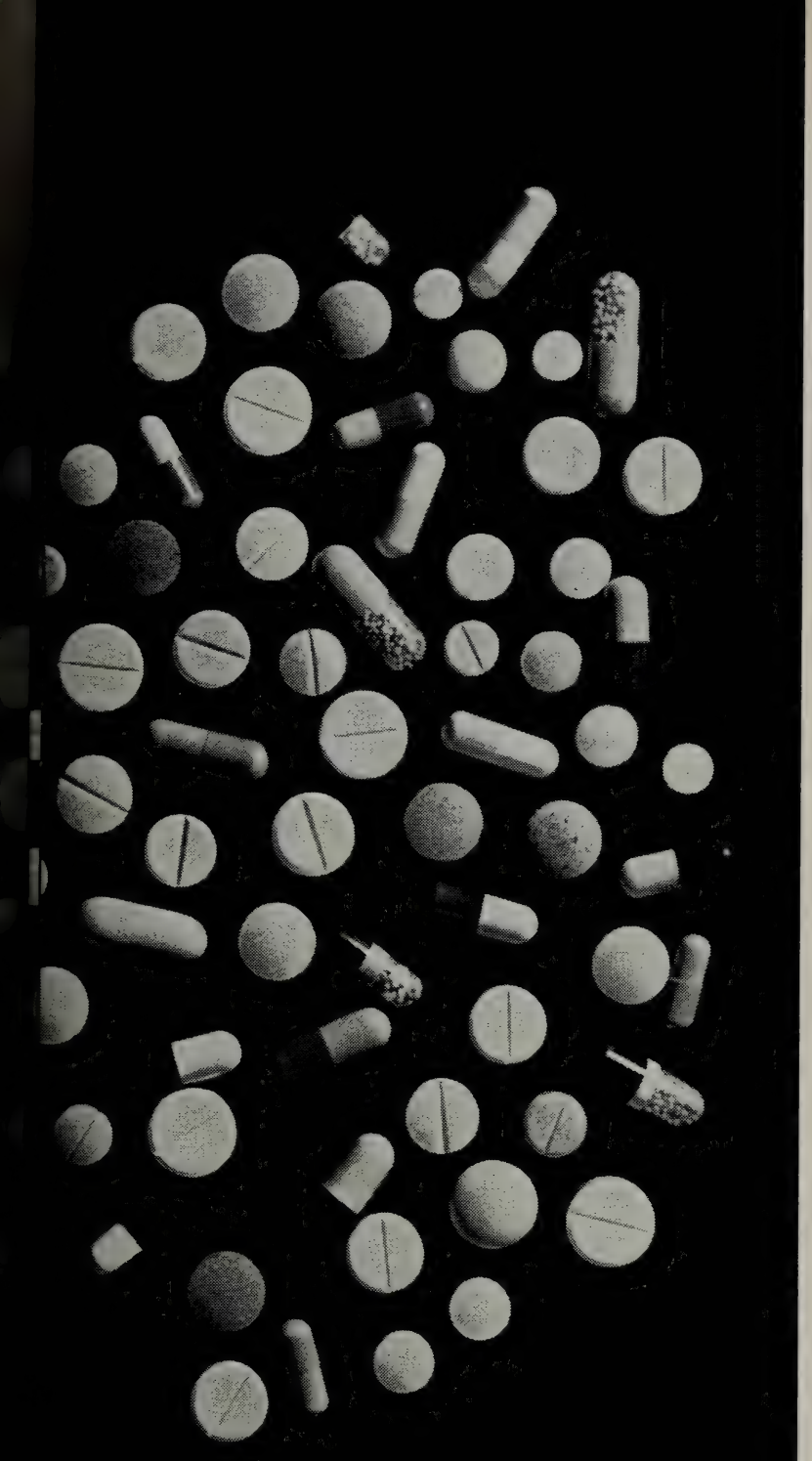
OMI Board of Directors

By official action, The Council **authorized President Crawford** to appoint a nominating committee to select nominees for the Ohio Medical Indemnity, Inc., Board of Directors, such nominees to be voted

(Continued on page 154)



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Precautions: Exercise caution in glaucoma, and with dosage forms containing phenobarbital, which may be habit forming. Full information available on request.

References: 1. Johnson, P. C., and Sevelius, G.: J.A.M.A. *173*:1231, 1960. 2. Data on file in the Medical Department, Warner-Chilcott Laboratories. Available on request. 3. Sadove, M. S.; Rosenberg, R.; Heller, F., and Shulman, M.: Am. Prof. Pharm. *31*:23, 1965. 4. Lumb, G. D., and Hardy, L. B.: Circulation (Pt. II, Cardiovascular Surgery) *27*:717, 1963.

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on at the annual OMI stockholders' meeting in April, 1966.

Fall District Conferences

Mr. Edgar reported on the Fall District Conferences and noted increased attendance and enthusiasm at these meetings which had representatives from 78 of 88 counties in attendance.

1966 County Society Officers Conference

It was announced by Mr. Edgar that the annual County Society Officers' Conference is scheduled for Sunday, February 27, at the Pick-Fort Hayes Hotel, Columbus. An outline of the program, presented by Mr. Edgar, **was accepted** by The Council.

Committee Reports

Military Advisory — Mr. Edgar reported on increased activities of the OSMA Medical Advisory Committee due to the build-up of military activities in Viet Nam. It was suggested by Dr. Tschantz that a communication be addressed to Selective Service Headquarters, suggesting that requests for medical information be postponed until after the Selective Service medical examination of the registrants.

Insurance — The Executive Secretary presented a report of the Committee on Insurance, based on the minutes of a meeting of that committee held on November 14, 1965. The report **was approved** as presented. This included approval of authorization to raise the ceiling on the OSMA group term life insurance from $20,000 to $40,000; travel accident insurance coverage for officers, councilors, committeemen, delegates, alternates and employees engaged in Association activities; income continuation insurance in event of disability occurring to State Association employees; and the exploration of a suggestion that a consultant or consultants be retained to assist the Association with insurance problems.

Several communications regarding the OSMA Major Medical Insurance Plan were referred to the Committee on Insurance.

Ad Hoc Committee on Education of the Committee on Mental Hygiene — Minutes of the meeting of this committee held on August 30, 1965 were discussed. The Council accepted the report for information and referred suggestions concerning psychiatric material for presentation in *The Ohio State Medical Journal* to the Editor of *The Journal* for his consideration. Item 2 regarding a pamphlet on commitment procedures to be prepared by the committee and distributed to all members with an *OSMAgram* and, subsequently, with the "new member packet" **was approved.**

Laboratory Medicine — The minutes of the meeting of the Committee on Laboratory Medicine held on September 22, 1965, were presented by Mr. Traphagan and **were accepted.**

A statement of policy with regard to county medical society bulletin advertising of laboratory services **was amended** to read as follows:

> "Based on the established policy of the Ohio State Medical Association, the practice of pathology is a part of the practice of medicine and in the judgment of The Council of the OSMA, it is improper for a county medical society publication to accept advertising proposing to perform clinical, pathological services."

Disaster Medical Care — Minutes of the meeting of the Committee on Disaster Medical Care held on November 21, 1965, **were approved.** The minutes dealt with the appointment of members of the OSMA committee as spokesmen for each of eight "emergency medical care districts" and four meetings in 1966 to train personnel to operate the stored packaged disaster hospitals. A communication to the Ohio Department of Education, stating that the OSMA has approved the Medical Self-Help Training Program for students in public and parochial schools, **was endorsed.**

Rural Health — Minutes of the meeting of the Committee on Rural Health held on October 6, 1965, **were approved.** With regard to a letter from the Western Reserve Medical Alumni Association, the committee voted to send a letter to the dean of the Western Reserve University Medical School, stating that if the medical school wants the student lectures for junior medical students and will cooperate in conducting the program, the committee will put forth its efforts at Western Reserve University as it has at Ohio State University and the University of Cincinnati. If the dean of the Western Reserve University Medical School does not answer the letter, The Council asked that the Western Reserve University Alumni Association be notified.

Subcommittee on Measles Education Campaign — A progress report on the measles education campaign presented by Mr. Gillen **was accepted.**

Hospital Relations — Mr. Gillen reported on the meeting of the Committee on Hospital Relations, held on November 24, 1965. A policy statement regarding nursing procedures **was amended and approved** as follows:

Emergency Nursing Procedures

> "The best interests of a patient requiring emergency treatment or emergency procedures will be served by permitting a competently trained registered nurse to render such needed emergency treatment or procedures not previously defined as accepted nursing care as may be authorized by the medical staff of the hospital or the medical advisory committee of the employing agency and and approved by the individual physician.
>
> "The ultimate decision as to the exact role and responsibility of the nurse in carrying out such emergency treatment and procedures must rest with

such medical staff or medical advisory committee and the individual physician."

Hospital-Based Services

A statement on hospital-based physician services **was amended and approved** as follows:

"The committee endorsed and fully supports the position taken by the American College of Radiology and the College of American Pathologists on relations between their specialties and the hospitals in which they practice.

"The committee recommended that the Ohio delegates to the AMA Clinical Meeting in Philadelphia be instructed to support any resolution which insists that hospital-based specialists bill separately for their services. The committee further requested that Ohio Medical Indemnity immediately develop policies that would pay hospital-based specialists' fees.

"It was announced that the Ohio Hospital Association has deferred action on the subject of having a joint meeting of the Ohio State Medical Association, Ohio Hospital Association, Blue Shield and Blue Cross to discuss the transferal of hospital-based physicians' fees from Blue Cross to Blue Shield plans. The committee instructed the secretary to arrange a meeting, as soon as possible, with representatives of the Ohio State Medical Association, Blue Shield and Blue Cross."

The Council requested that a letter be directed by Dr. Crawford to the Ohio State Radiological Society, the Ohio Society of Pathologists and the Ohio Hospital Association advising of the action of the Ohio State Medical Association with regard to separate billing for physicians' services.

Dr. Fulton reviewed correspondence from Dr. William B. Schwartz, Columbus, and a communication from Dr. Schwartz to the administrator of Riverside Hospital, Columbus, concerning a separate billing for radiological services. The Council requested that a letter be sent to Dr. Schwartz, advising him that his communication had been discussed by members of The Council and encouraging him to proceed with his action to establish separate billing for radiological services at Riverside Hospital. In addition, it was requested that Dr. Schwartz receive a copy of the minutes of the meeting of the Committee on Hospital Relations held on November 24 and a copy of the American Medical Association Principles of Medical Ethics, Section 6.

Hospital Directors of Medical Education

A report on replies of hospital directors of medical education concerning a survey on forming an Ohio section of hospital directors of medical education was referred to the Committee on Hospital Relations for study, with instructions for the committee to report to the next meeting of The Council.

Conference of Chairmen of County Hospital Relations Committees

A conference of chairmen of county committees on hospital relations **was approved** as a part of the report.

Adherence to AMA Policies—"Model Agreement" and Utilization Committees

Also approved as a part of the minutes were two resolutions introduced by the Ohio Delegation at the November 28 - December 1 session of the AMA House of Delegates in Philadelphia. One resolution requested adherence to AMA House of Delegates policies with regard to an AMA-issued "model agreement" between physicians and hospitals and another insisting that utilization committees **shall** be composed of practicing physicians.

OHA Coordinating Committee

The matter of appointments to represent the Ohio State Medical Asosciation on the Ohio Hospital Association Coordinating Committee for Health Facility Planning was discussed. The following appointments were announced by the President: Dr. William R. Schultz, Wooster; Dr. Oscar Clarke, Gallipolis; Dr. Homer A. Anderson, Columbus; Mr. Herbert E. Gillen, Columbus; Dr. David A. Chambers, Cleveland; Dr. Jonathan G. Busby, Columbus; Dr. Robert M. Craig, Dayton; Dr. Lloyd Larrick, Cincinnati; Dr. J. Lester Kobacker, Toledo.

Medicare

A letter from the Health Insurance Council regarding insurance companies and Medicare was reviewed. The Council **authorized the staff** to confer with representatives of the Health Insurance Council regarding problems arising as a result of the passing of the Medicare Act.

A letter from the Summit County Medical Society regarding a request that the Summit and Portage County Medical Societies have a voice in the selection of the Medicare carrier chosen for their area was duly noted and referred to Ohio Medical Indemnity, Inc.

The Ohio State Medical Journal

Reports from Dr. Perry R. Ayres, Editor of *The Ohio State Medical Journal* and from Mr. Moore on the progress of *The Journal* **were accepted.**

Charters and Bylaws

The Council granted a request for the reissuance of a charter to the Jackson County Medical Society.

With regard to proposed amendments to the Lorain County Constitution and Bylaws, the OSMA legal counsel was authorized to write to the Lorain County Medical Society with suggestions as to what changes in the language would be indicated in order to meet the purpose of the amendments.

It was announced that amendments which had

been submitted by the Wayne County Medical Society were defeated in a recent meeting of the society.

Dependents' Medical Care

A communication from the Office for Dependents' Medical Care, granting certain fee increases for tonsillectomy anesthesia and for a variety of otolaryngological procedures, was reported to The Council.

Small Claims Courts in Ohio

Correspondence proposing small claims courts in Ohio was accepted for information.

Welfare Advisory Committee

The President was authorized to appoint a representative of the Ohio State Medical Association to the Department of Public Welfare Advisory Committee on the matter of the development of the department's medical assistance program.

Belmont County

Belmont County developments were discussed.

Community Service Award

A request from the A. H. Robbins Company to participate in its Community Service Award Project was declined with thanks.

Woman's Auxiliary

The following amendment to Article VII, Section 7 of the Constitution and Bylaws of the Woman's Auxiliary **was approved:**

Amend by changing 30 days to 90 days and insert after the first sentence the following: "Not less than 60 days before the annual meeting all resolutions approved by the Advisory Committee and the Resolutions Committee shall be sent to each component auxiliary."

A second amendment to Article VIII, Section 5, C-2, C-1, also approved by Council, is a deletion of "2) be Membership Chairman." This would provide for a membership chairman instead of having that duty one of the duties of the President-Elect.

Also **approved** was the following resolution on joining a number of counties into one auxiliary:

"Whereas, The Woman's Auxiliary to the Ohio State Medical Association has been working to organize every county auxiliary in the State of Ohio for the past 25 years,

"Whereas, We have organized every possible county and have reached a stalemate,

"We, the Woman's Auxiliary to the Ohio State Medical Association, request permission to unite two or more of the counties to form one organization as it is done in other states."

The Council **disapproved** the following resolution regarding team membership:

"Whereas, The Woman's Auxiliary to the Ohio State Medical Association has worked on membership for 25 years and has a membership of approximately 5,600 members from a potential of about 9,000,

"Whereas, The Woman's Auxiliary to the Ohio State Medical Association could improve the quality and quantity of the work they are doing with the additional dues and members,

"Whereas, The Woman's Auxiliary to the Ohio State Medical Association could spend the time devoted to obtaining new members to doing other important work,

"Whereas, The American Medical Association has endorsed the 100 per cent team membership,

"Whereas, The money for the dues comes from the same source,

"We, the Woman's Auxiliary to the Ohio State Medical Association, request the permission and cooperation of the Ohio State Medical Association to promote 100 per cent team membership of the Woman's Auxiliary - Ohio State Medical Association and the Ohio State Medical Association. That is, at the time the doctor pays his county, state and national dues to his medical association, he will also pay those of his wife."

Workmen's Compensation

Mr. Edgar reported on the progress of the usual and customary fee program of the Bureau of Workmen's Compensation and announced that a conference of OSMA officers and staff would be held with the officials of the Bureau on December 16, 1965.

Reports on Meetings

Dr. Crawford reported on meetings of the Michigan and West Virginia State Medical Associations which he had attended. Dr. Meredith discussed the Kentucky and Indiana State Medical Society meetings at which he represented the President.

Reports to The Council on other meetings attended were as follows:

AMA National Conference on Physicians and Schools, Chicago, September 24-25, 1965 — Mr. Gillen.

Emergency Hospital Training Program, October 17, 1965 — Mr. Traphagan.

First Ohio Congress on Psychological Medicine, October 24 — Mr. Traphagan.

American Medical Political Action Committee Conference, Chicago, November 5 — Mr. Page and Mr. Stichter.

Institute on Areawide Planning of Health Facilities, November 7, 1965 — Mr. Gillen.

Ohio Hospital Association Institute on Long Term Care, November 19 — Mr. Gillen.

Legislation

Correspondence with Dr. Arthur D. Collins, Cleveland, chairman of the OSMA Committee on Eye Care,

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

TAO®
[triacetyloleandomycin]

ROERIG Rx

J. B. Roerig and Company, New York, New York 10017
Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being®

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

regarding S. B. 2568, the Hart Bill, was discussed. The President was authorized by The Council to discuss the matter with Dr. Collins.

Ohio Health Commissioners

With regard to a request from the Ohio Health Commissioners' Association, the staff **was authorized** to communicate with that Association regarding meetings of the Committee on Environmental and Public Health, inviting the representatives of that Association to attend when matters on the agenda indicate that such is advisable.

ATTEST: HART F. PAGE,
Executive Secretary.

Western Reserve Project Applies Smear Test to Dental Patients

A grant from the U. S. Public Health Service is supporting a case-finding project at the Western Reserve University School of Dentistry based on detection of mouth cancer through an exfoliative cytology technique applied to the oral cavity.

Western Reserve has one of 20 such laboratories in major centers across the country. The case finding program is being conducted primarily among service patients of the dental clinic, but private patients may be referred at nominal fees.

One in Ten Ohio Automobiles Found Unsafe for Driving

More than ten per cent of the vehicles checked in the 1965 Ohio Safety-Check Program were in unsafe driving condition, the Ohio Department of Highway Safety reported. Rear lights, tires and brakes were the items found most frequently to be in unsafe condition.

Safety-check programs sponsored in Ohio were part of the national program. A total of 379,924 vehicles were checked in Ohio. Of these, 38,577 were rejected because of one or more defects. Forty-eight per cent of the rejected vehicles were re-checked.

Twenty-six per cent of the vehicles checked had seat belts installed. A seat belt use survey showed that 55 per cent of the drivers questioned always use seat belts for local travel while 68.6 per cent always use them for long trips.

A new Ohio law requires all automobiles manufactured on or after January 1, 1966 to have the front seats equipped with safety belts.

The Catholic Medical Mission Board, Inc., last year shipped over 2,592,000 pounds of medical supplies to mission hospitals throughout the world. Persons interested in more information about this effort are invited to contact the board at 10 West 17th Street, New York, N. Y. 10011.

Deadline for Submission of Resolutions to Columbus Office of the Association Is March 25

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1966 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Tuesday evening, May 24, at the Sheraton-Cleveland Hotel, Cleveland.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 25. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting intructions from their County Medical Societies.

APPLICATION FOR SPACE, SCIENTIFIC AND HEALTH EDUCATION EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 1966 ANNUAL MEETING, SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 24 - 28

1. **Title of Exhibit:** _____

2. **Name(s) of Exhibitor(s):** _____

_____

Institution (if desired): _____

City _____

3. **Do you have a built-in exhibit?** _____

4. **Description of Exhibit: (Attach 200 word description to this blank)**

5. **Exhibit will consist of the following: (Check which)**

Charts and posters_____ **Photographs**_____ **Drawings**_____ **X-rays**_____

Specimens_____ **Moulages**_____ **Other material**_____
(Describe)

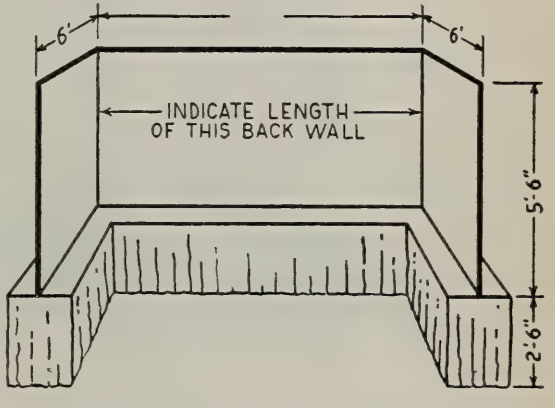
6. **Booth Requirements:**

Amount of wall space needed?_____

Back wall_____ **Side walls**_____

Square feet needed?_____

Shelf desired? (yes or no) _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

7. **Transparency Cases:**

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

_____

_____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date_____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND HEALTH EDUCATION EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS, OHIO 43215

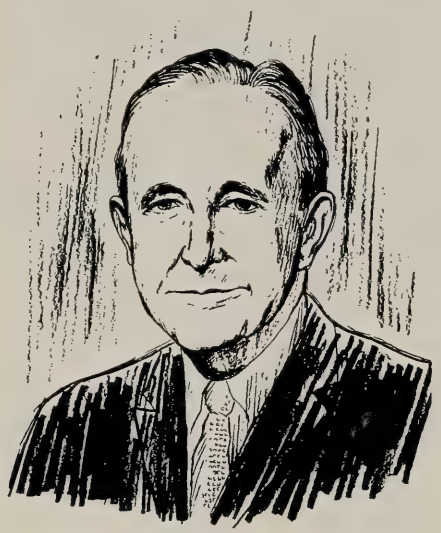
DEADLINE FOR FILING APPLICATIONS FEBRUARY 28, 1966

1966 Annual Meeting

HIGHLIGHTS A NEW LOOK

THURSDAY, MAY 26
GENERAL SESSION
(Gold Room, Mezzanine Floor)

1:30 P. M.
"Medicare's Rules and Regulations and their Effect on the Practice of Medicine."



CHARLES L. HUDSON, M. D.
Cleveland, Ohio
President-Elect, American Medical Association

Dr. Hudson will present detailed information regarding the rules and regulations of Public Law 89-97, which becomes effective July 1, 1966. He has participated in the activities of the AMA's Task Force in its consultations with the Federal Government on the development of these rules and regulations. Dr. Hudson will answer questions from the audience following his formal presentation.

FRIDAY, MAY 27
GENERAL SESSION
(Gold Room, Mezzanine Floor)

1:30 P. M.
"Care of the Patient: 1966"



EDWARD R. ANNIS, M. D.
Miami, Florida
Past President, American Medical Association

Dr. Annis will make his presentation on the theme of the 1966 OSMA Annual Meeting. He will look at the future of patient care and the effect of the various pieces of Federal legislation upon the traditional physician-patient relationship. A question and answer period will follow Dr. Annis' formal presentation.

The New Look of the 1966 Annual Meeting is planned with emphasis on a fast paced schedule to accommodate the busy physician. New features include "name" guest speakers preceding scientific section meetings; a larger and better scientific exhibit; medical booth seminars presenting practical demonstrations of procedures of interest; and emphasis throughout the meeting on brief, snappy papers on current medical topics.

MEDICAL BOOTH SEMINARS

These one-half hour booth seminar presentations will feature practicel demonstrations of equipment and procedures that may be used in everyday practice. As you will note, three of the presentations will be running simultaneously beginning at 9:00, 10:00 and 11:00. The other three beginning at 9:30, 10:30 and 11:30. It is hoped that physicians will have an opportunity to view all of the presentations on Friday morning.

FRIDAY, MAY 27

(Exhibit Hall Area)

Starting Time: 9:00, 10:00 and 11:00 A. M.

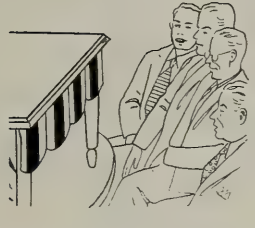
Booth No. 1 **"Conditioning, Prevention and First Aid for Athletic Injuries"**

MR. ERNEST R. BIGGS
Columbus, Ohio

Head Athletic Trainer, Ohio State University

Chairman of Committee on Injuries, National Athletic Trainers Association

Member, Committees on Competitive Safeguards and Medical Aspects of Sports, National Collegiate Athletic Association



Booth No. 3 **"Bedside Pulmonary Function Testing"**

JOSEPH F. TOMASHEFSKI, M. D.
Columbus, Ohio

Assistant Professor of Medicine and Associate Professor of Preventive Medicine and Physiology, O. S. U. College of Medicine and Chief of Research and Director of Cardiopulmonary Laboratories, Ohio Tuberculosis Hospitals

Booth No. 5 **"Physical Medicine in the Home"**

ERNEST W. JOHNSON, M. D.
Columbus, Ohio

Professor and Chairman of the Department of Physical Medicine, The Ohio State University College of Medicine

Starting Time: 9:30, 10:30 and 11:30 A. M.

Booth No. 2 **"Resuscitation"**

JOHN H. KENNEDY, M. D.
Cleveland, Ohio

Surgeon-in-charge of thoracic surgical services, Cleveland - Metropolitan General Hospital and Assistant Professor of Thoracic Surgery, Western Reserve University

JOHN HOMI, M. D.
Cleveland, Ohio

Department of Anesthesiology, Cleveland Clinic Foundation

HENRY E. KRETCHMER, M. D.
Cleveland, Ohio

Associate Professor of Anesthesiology, Western Reserve University School of Medicine

Director, Department of Anesthesiology at Cleveland Metropolitan General Hospital

Booth No. 4 **"Lacerations"**

H. W. PORTERFIELD, M. D.
Columbus, Ohio

Instructor, Department of Surgery, Ohio State University College of Medicine

Private Practice of Plastic Surgery

S. W. HARTWELL, JR., M. D.
Cleveland, Ohio

Department of Plastic Surgery, Cleveland Clinic Foundation

DONALD M. GLOVER, M. D.
Cleveland, Ohio

Clinical Professor of Surgery, Emeritus, Western Reserve University School of Medicine

Booth No. 6 **"Fractures"**

CHARLES M. EVARTS, M. D.
Cleveland, Ohio

Staff, Department of Orthopedic Surgery, Cleveland Clinic Foundation

KENT L. BROWN, M. D.
Cleveland, Ohio

Assistant Surgeon, St. Luke's Hospital

SCHEDULE of EVENTS in BRIEF

TUESDAY, MAY 24

5:00 P. M.
(Mezzanine Floor)
OSMA House of Delegates
REGISTRATION

6:00 P. M.
(Whitehall Room, Mezzanine Floor)
OSMA House of Delegates
COMPLIMENTARY DINNER

7:30 P. M.
House of Delegates
FIRST BUSINESS SESSION
(Gold Room, Mezzanine Floor)

Herbert Morris Platter, M. D., Secretary of the Ohio State Medical Board for 48 years, to whom the entire 1966 Annual Meeting is dedicated will be honored.

WEDNESDAY, MAY 25

9:00 A. M.
Resolution Committee No. 1
(Whitehall Room, Mezzanine Floor)
Resolution Committee No. 2
(Empire Room, Parlor Floor)
Resolution Committee No. 3
(Terminal Room, Parlor Floor)
REGISTRATION FOR EXHIBITORS OPEN
(Grand Ballroom Foyer, Mezzanine Floor)

10:00 A. M.
OSMA REGISTRATION OPENS
(Grand Ballroom Foyer, Mezzanine Floor)
Scientific, Health-Education and Technical
Exhibits Open
(Grand Ballroom and Ballroom Balcony)

11:30 A. M.
Ohio Medical Political Action Committee
American Medical Political Action Committee
LUNCHEON
(Gold Room, Mezzanine Floor)
Speaker: HOYT D. GARDNER, M. D.
Louisville, Kentucky
Member, Board of Directors, AMPAC

WEDNESDAY (Contd.)

1:00 P. M.
Ohio Health Commissioners' Meeting with Director
(Grand Ballroom — Terrace, Parlor Floor)

1:30 P. M.
GENERAL SESSION
(Cleveland Room, Lobby Floor)
"Problems in Marriage"

Sponsored by: Section on Psychiatry and Neurology; Ohio Psychiatric Association and cosponsored by all other sections and OSMA Committee on Medicine and Religion.

2:00 P. M.
Ohio Health Commissioners' Institute
FIRST SESSION
(Grand Ballroom — Terrace, Parlor Floor)

2:00 P. M.
Section on Ophthalmology
and
Ohio Ophthalmological Society
(Lewis Room, Lobby Floor)

3:00 P. M.
INTERMISSION FOR TOUR OF EXHIBITS

3:30 P. M.
GENERAL SESSION
(Gold Room, Mezzanine Floor)
"What I Do About It"

Sponsored by: The Faculty of Western Reserve University College of Medicine.

3:30 P. M.
Continuation of Scientific Section Meetings

THURSDAY, MAY 26

8:30 A. M.
(Gold Room, Mezzanine Floor)
"A New Look at Tetanus Prophylaxis"
Film sponsored by the Ohio Committee on Trauma, American College of Surgeons

9:00 A. M.
OSMA REGISTRATION OPENS
(Grand Ballroom Foyer, Mezzanine Floor)
Scientific, Health-Education and Technical
Exhibits Open
(Grand Ballroom and Ballroom Balcony)

THURSDAY (Contd.)

9:00 A. M.

GENERAL SESSION
(Gold Room, Mezzanine Floor)

"Athletic Injuries"

Cosponsored by Ohio Committee on Trauma, American College of Surgeons; Joint Advisory Committee on Athletic Injuries of the OSMA; and the Ohio High School Athletic Association.

9:30 A. M.

Executive Session of Resolution Committee No. 1
(Wigwam Room, First Floor)

Executive Session of Resolution Committee No. 2
(Mohawk Room, First Floor)

Executive Session of Resolution Committee No. 3
(Chieftain Room, First Floor)

9:30 A. M.

Ohio Health Commissioners' Institute
SECOND SESSION
(Lewis Room, Lobby Floor)

9:30 A. M.

Annual Meeting of Ohio Psychiatric Association
and
OSMA Section on Psychiatry and Neurology
(Grand Ballroom — Terrace, Parlor Floor)

10:30 A. M.

INTERMISSION FOR TOUR OF EXHIBITS

11:00 A. M.

Continuation of General Session and
Scientific Section Meetings

1:30 P. M.

GENERAL SESSION
(Gold Room, Mezzanine Floor)

CHARLES L. HUDSON, M. D.
President-Elect, American Medical Association

2:30 P. M.

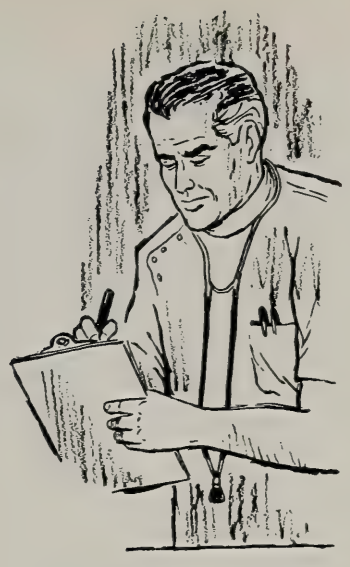
INTERMISSION FOR TOUR OF EXHIBITS

3:00 P. M.

OSMA Section on Anesthesiology
(Terminal Room, Parlor Floor)

Section on Internal Medicine
and
Ohio Society of Internal Medicine
(Gold Room, Mezzanine Floor)

Section on Psychiatry and Neurology
and
Ohio Psychiatric Association
(Grand Ballroom — Terrace, Parlor Floor)



THURSDAY (Contd.)

Ohio Health Commissioners' Institute
THIRD SESSION
(Lewis Room, Lobby Floor)

Ohio Academy of Medical History
(Erie Room, Parlor Floor)

Ohio State Surgical Association
(Whitehall Room, Mezzanine Floor)

FRIDAY, MAY 27

7:30 A. M.

WOMAN'S AUXILIARY BREAKFAST
for
Physicians and Auxiliary Members
(Cleveland Room, Lobby Floor)

9:00 A. M.

OSMA House of Delegates
FINAL BUSINESS SESSION
(Gold Room, Mezzanine Floor)

9:00 A. M.

OSMA REGISTRATION OPENS
(Grand Ballroom Foyer, Mezzanine Floor)

Scientific, Health-Education and Technical
Exhibits Open
(Grand Ballroom and Ballroom Balcony)

Medical Booth Seminars
(Exhibit Hall Area)

9:30 A. M.

Ohio Health Commissioners' Institute
FOURTH SESSION
(Lewis Room, Lobby Floor)

10:30 A. M.

Ohio State Surgical Association
(Business meeting to be followed by luncheon)

(Continued on Next Page)

FRIDAY (contd.)

1:30 P. M.

GENERAL SESSION
(Gold Room, Mezzanine Floor)
"Care of the Patient: 1966"
EDWARD R. ANNIS, M. D.
Past President, American Medical Association

2:30 P. M.

INTERMISSION FOR TOUR OF EXHIBITS

3:00 P. M.

Section on General Practice

Section on Obstetrics and Gynecology

Section on Pediatrics
Ohio Chapter, American Academy of Pediatrics
(Gold Room, Mezzanine Floor)

Section on Ear, Nose and Throat
and
Ohio Ear, Nose and Throat Society
(Terminal Room, Parlor Floor)

Section on Occupational Medicine
(Erie Room, Parlor Floor)

Section on Physical Medicine and Rehabilitation
Ohio Society of Physical Medicine and Rehabilitation
(Navajo Room, First Floor)

Section on Orthopaedic Surgery
and
Ohio Orthopaedic Society
(Lewis Room, Lobby Floor)

Section on Radiology
Ohio Chapter, American College of Chest Physicians
(Whitehall Room, Mezzanine Floor)

Section on Pathology
The Ohio Society of Pathologists
(Cleveland Room, Lobby Floor)

Section on Neurological Surgery
Ohio Neuro-Surgical Society
(Empire Room, Parlor Floor)

3:00 P. M.

ALL EXHIBITS CLOSED

6:30 P. M.

OSMA PRESIDENT'S RECEPTION
(Whitehall and Gold Rooms, Mezzanine Floor)

SATURDAY, MAY 28

9:00 A. M.

REGISTRATION
(Grand Ballroom Foyer)

Conference on Laboratory Medicine
(Gold Room, Mezzanine Floor)

Cosponsored by OSMA Committee on Laboratory Medicine and Ohio Association of Blood Banks.

12:00 Noon

ANNUAL MEETING CLOSES

New Provisions in OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to new provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cleveland, May 24 - 28.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 28.

The revised section in the OSMA Bylaws pertaining to the procedure reads as follows:

Section 1 (a). Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates, provided however that only those candidates may be nominated whose names have been filed with the Executive Secretary at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon filing of such candidate's name, the Executive Secretary, if such candidate is eligible for election, shall prepare and transmit this information to each member of the House of Delegates. No candidate may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the Delegates present at the opening session of such meeting. The Executive Secretary shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all eligible candidates meeting the requirements of filing and transmittal.

she's pleased she's on

Provest®

a significantly different oral contraceptive

(medroxyprogesterone acetate with ethinyl estradiol)



New Drug Abuse Law . . .

Physicians Not Required to Keep Records Unless They Dispense Certain Drugs and Charge for Them

ON February 1, Public Law 89-74, the Drug Abuse Control Amendments of 1965, aimed at curbing drug abuse through curtailment of illicit drug traffic, became effective. The law establishes special controls over the manufacture and distribution of depressant and stimulant drugs.

Among the controls is the requirement for the keeping of records of the manufacture, sale, delivery, and receipt of such drugs. This matter of record-keeping is of particular importance to physicians, particularly because there has been some confusion as to what records a physician must keep under the provisions of P. L. 89-74, 89th Congress.

Mr. C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association and former director of the American Medical Association's Law Department, points out that "**Physicians are not required to keep records as a consequence of this law unless, in the course of their practice, they dispense the drugs referred to in the law and charge for them.**"

Record-Keeping

To illustrate his point, Mr. Stetler cites a part of the law relating to record-keeping, which reads:

> "The provisions of paragraphs (1, Records) and (2, Inspection) of this subsection shall not apply to a licensed practitioner . . . with respect to any depressant or stimulant drug received, prepared, processed, administered, or dispensed by him in the course of his professional practice, unless such practitioner regularly engages in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services."

Mr. Stetler explains that the significant phrases in this paragraph are the words "regularly engages" and "for which they are charged." He continues, "Further in this regard is a quote from the report of the U. S. House of Representatives Committee on Interstate and Foreign Commerce . . ."

> "The committee intends . . . to require record-keeping and to permit inspection in the case of those physicians who **maintain** a supply of pharmaceuticals or medicinals in their offices from which they compound prescriptions for their patients **for a fee.**"

"The language of the Senate Committee report is identical," reports Mr. Stetler, "and both committee reports stated that those required to keep records 'involve only a very small percentage of physicians.' "

The proposed regulations underscore this point, indicating that ". . . **maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee.**" (Emphasis added.)

Dispensing of Drugs

For those physicians who, in the course of their practice, regularly dispense drugs and charge for them, certain records are required to be kept for three years, effective February 1. Included are:

(1) A complete, accurate record of all depressant and stimulant drugs on hand February 1, 1966;

(2) A complete, accurate record of the kind and quantity of each drug received, sold, delivered or otherwise disposed of;

(3) The name, address (and registration number under Section 510(e) of the Federal Drug and Cosmetic Act) of the person from whom the drugs were received, and to whom they were sold, delivered, dispensed or otherwise disposed of; and

(4) The date of the transaction.

No separate, special form for these records will be required as long as the information is readily available, officials report.

The system of record-keeping was designed to permit government agents to follow the movement of all of these prescription drugs from producer to consumer.

The U. S. Commissioner of Food and Drugs is authorized to determine that a stimulant or depressant

drug has a potential for abuse, and therefore should be covered under the law, if there is evidence of:

1. Individuals taking the drug in amounts sufficient to create a hazard to their health or to the safety of other individuals or the community.
2. Significant diversion of the drug from legitimate drug channels.
3. Individuals taking the drug on their own initiative rather than on advice of a physician licensed by law to administer such drugs.

However, to reiterate, under P. L., 89-74, physicians do not have to keep records unless they regularly dispense and charge for the drugs covered by the Act.

To further understand the details of this law, physicians may obtain a copy of the pamphlet "H. R. 2 and You" from the American Pharmaceutical Association, 2215 Constitution Avenue, N. W., Washington, D. C., 20037. Single copies of this reference guide to the Drug Abuse Control Amendments of 1965 are available free of charge.

Ohio Licensed Practical Nurses Announce New Organization

Following a statewide meeting on November 18 in Columbus, an announcement was issued of formation of the Ohio Federation of Licensed Practical Nurses. Bylaws were adopted and temporary officers were elected.

Temporary officers are: Mrs. Irene Monkowski, L. P. N., 1643 Bunts Road, Lakewood, president; Mrs. Isabelle Mulchany, L. P. N., 2450 Northview Road, Rocky River, secretary; and Mrs. Jean Rice, L. P. N., 521 Zeller Court, Berea, treasurer.

The November meeting followed a previous meeting on April 26 in Cleveland. The earlier meeting was arranged by a steering committee consisting of delegates from Alumnae Associations of Schools of Practical Nursing.

The Ohio Federation of Licensed Practical Nurses will be a constituent of the National Federation of Licensed Practical Nurses (NFLPN).

It was voted at the November meeting to hold another statewide meeting in April in Columbus, date and place of which is to be announced.

All licensed practical nurses are eligible for membership. Dues are $12.00 annually. Nine dollars will be held by the state organization to develop state programs. Three dollars will be forwarded to the national headquarters. Payment of dues entitles the member to a subscription to the NFLPN bi-monthly publication, *The American Journal of Practical Nursing*. All qualified applicants whose dues have been received by the April meeting will be charter members of the state organization.

Provisions have been made to include student affiliates from students enrolled in schools of practical nursing.

Venerable Medical Board Secretary Retires After 48-Year Record

Herbert Morris Platter, M. D., secretary of the State Medical Board of Ohio since 1917, retired from that post at the end of the year and climaxed a career that has done much to promote the highest standards of practice in this State.

Dr. Platter's achievements and the honors bestowed upon him are numerous and impressive. He is a Past-President of the Ohio State Medical Association, Past-President of the Academy of Medicine of Columbus and Franklin County, Past-President of the Federation of Licensing Boards, a practicing physician of long standing in Columbus where he specialized in dermatology, and a former member of the faculty at Ohio State University College of Medicine where he lectured on dermatology and medical law.

In 1964, the Executive Committee of the Federation of State Medical Boards of the United States put on record a resolution entitled "The Impact of Herbert Morris Platter, M. D., on American Medicine." Here is an excerpt: "He possesses the rare ability of always rendering service in all of his many activities. He is well known for his unyielding faith in his fellow man and a firm belief in American Medicine and is one of the nation's outstanding physicians of all times."

At the 1964 Annual Convention of the American Medical Association in San Francisco, Dr. Platter was honored before the House of Delegates when he received the AMA Certificate of Merit. Dr. Platter was secretary of the AMA Committee on Arrangements for the AMA meeting in Columbus in 1899, the meeting at which the Scientific Exhibit was established.

Dr. Platter again will be honored by the Ohio State Association at the 1966 OSMA Annual Meeting in Cleveland, May 24-28, for his years of service to the medical profession and to the public. The entire meeting has been dedicated in his honor.

Dr. Platter, who will celebrate his 97th birthday on June 18, is making his residence at the Lutheran Senior City, Inc., 977 Parkview Avenue, Columbus 43219. His many friends may wish to correspond with him at that address.

Dr. Robert A. Hingson, Cleveland, was special speaker for the December 14 dinner meeting of the Fort Steuben Academy of Medicine in the Fort Steuben Hotel, Steubenville. His subject was "Specialty of Anesthesia Prepares for the Last Quarter of the 20th Century to Serve All Branches of Medicine." A presentation of slides illustrated worldwide application of anesthesia.

OMPAC Memberships Rolling In ...

Physicians Totaling 1,227, From 56 Counties Have Joined Up To January 20; Board of Directors Enlarged; Officers Are Elected

ALTHOUGH collection of 1966 Ohio Medical Political Action membership dues has been in process only since January 1, as of January 20, a total of 1,227 physicians have affiliated with OMPAC, according to Dr. Carl A. Lincke, Carrollton, secretary-treasurer of OMPAC.

The 1966 OMPAC dues are being collected by the secretary-treasurers of County Medical Societies along with medical society dues. Payment is optional on the part of each individual physician. The County Medical Societies will be reimbursed by OMPAC for expenses incurred by them in collecting OMPAC dues.

AMPAC Gets Part of Dues

If there is any county where the County Medical Society is not collecting OMPAC dues, physicians may join OMPAC by paying the $25.00 annual dues to OMPAC direct — P. O. Box 5617, Columbus, Ohio 43221.

A portion of each member's annual dues — an amount of $10.00 — is contributed to the American Medical Political Action Committee, Chicago, for its activities on a national basis. This amount qualifies each Ohio member for membership in the American Medical Political Action Committee. OMPAC membership cards will be sent to members by the Ohio committee; AMPAC membership cards by the national committee.

Affiliates from 49 Counties To Date

OMPAC 1966 dues have been received from physicians in 56 counties up to January 20. Many of these counties are still in the process of collecting dues as are those counties which have not as yet reported to OMPAC. Following is a list of counties from which 1966 OMPAC dues have been certified, with the number of OMPAC members certified as of January 20, shown in parenthesis:

Adams (1), Allen (66), Ashland (6), Ashtabula (14), Athens (12), Auglaize (2), Belmont (18), Brown (6), Butler (49), Carroll (6), Clark (51), Clermont (4), Crawford (35), Cuyahoga (72), Defiance (1), Fairfield (1), Fayette (12), Franklin (2), Geauga (10), Greene (19), Guernsey (3), Hancock (3), Harrison (6), Jefferson (2), Lake (42), Lawrence (14), Licking (1), Lorain (48), Lucas (3), Mahoning (74), Marion (6), Medina (14), Miami (35), Montgomery (191), Morrow (2), Muskingum (23), Noble (1), Ottawa (6), Perry (3), Pickaway (5), Ross (18), Sandusky (8), Scioto (33), Stark (148), Trumbull (44), Tuscarawas (17), Wayne (27) Wood (2), Wyandot (3).

Other counties which have certified are: Darke (7), Henry (7), Hocking (1), Knox (25), Paulding (1), and Shelby (15).

OMPAC Board Enlarged

At a recent meeting of the Board of Directors of the Ohio Medical Political Action Committee in Columbus, the members of the board who have been administering the activities of OMPAC since its founding in the Fall of 1963 were re-elected and six new members elected in order to give the board more geographical representation.

Current members of the Board of Directors are: Frank H. Mayfield, M. D., Cincinnati; George M. Petznick, M. D., Cleveland; Carl A. Lincke, M. D., Carrollton; Edwin H. Artman, M. D., Chillicothe; Robert S. Martin, M. D., Zanesville; anl Mrs. Edward E. Bauman, Warren, all of whom have been serving on the Board, and the following new members: Thomas D. Allison, M. D., Lima; Edward L. Doermann, M. D., Toledo; Jack L. Kraker, M. D., Lancaster; William J. Lewis, M. D., Dayton; James C. McLarnan, M. D., Mt. Vernon; and H. William Porterfield, M. D., Columbus. One original member of the board — Dr. C. C. Sherburne, Columbus — died on November 13, leaving a vacancy which was filled at the board meeting.

Officers Elected

Officers for 1966 were elected as follows: Chairman, Dr. Mayfield; vice-chairman, Dr. Petznick; and secretary-treasurer, Dr. Lincke, filling the vacancy in that office which had been held by Dr. Sherburne.

The Board, by a standing vote, adopted a resolution in memory of Dr. Sherburne, in which his efficient and loyal services on behalf of the objectives of OMPAC were emphasized.

Luncheon in Cleveland Planned

Proposal for an OMPAC luncheon on May 25 at the Cleveland Sheraton Hotel during the 1966 Annual Meeting of the Ohio State Medical Association was approved by the board. An offer from the Woman's Auxiliary of the Ohio State Medical As-

sociation to co-sponsor the luncheon and help in the sale of luncheon tickets was accepted by the board with an expression of appreciation. Tickets will be sold before, and during, the Annual Meeting. The luncheon will be open to physicians and their wives, and their guests. A program designed to describe the activities and objectives of AMPAC and OMPAC and to summarize some of the vital political and legislative problems confronting the medical profession during 1966 is being arranged.

OMPAC will have a booth at the Annual Meeting in Cleveland at which members may obtain literature and submit questions about OMPAC's organization and activities. Those who may desire information immediately concerning OMPAC's program should direct their inquiry to OMPAC, P. O. Box 5617, Columbus, Ohio 43221, and literature will be sent to them.

VA Policy Announced Regarding Treatment of Certain GIs

Veterans recently discharged from the Armed Forces, who require immediate care for disabilities apparently incurred in service, may now be entitled to both outpatient treatment and hospitalization from the Veterans Administration, according to an official announcement from VA headquarters.

VA has liberalized its rules to allow medical and dental treatment at any of its clinics as well as care in any of its hospitals, as needed, during the period required for a veteran to establish that his disability was service incurred.

In an emergency, a recently discharged veteran awaiting adjudication of his claim to connect his injuries to his service, may obtain care at non-VA facilities at VA expense, when VA facilities are not available. However, the veteran should remember that prior approval of the VA is necessary in such cases.

Only veterans discharged or released with an honorable or general discharge after six or more months of active duty are eligible for hospitalization or outpatient treatment while awaiting VA recognition of their claimed disabilities.

In addition, application for VA medical care must be made within six months of the veteran's discharge or release from service.

The outpatient medical, dental and hospitalization privileges cease immediately when the VA adjudication board denies a veteran's claim that his disability was related to his military service, the VA said.

The American College of Physicians has issued information on a number of postgraduate courses in cooperation with medical educational institutions throughout the country. Several courses are scheduled in areas convenient for Ohio physicians. Details may be obtained from the American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Canton Physician Named to State Medical Board

Dr. Ralph K. Ramsayer, of Canton, has been appointed to the State Medical Board by Governor James A. Rhodes, to complete the unexpired term of Dr. William Hoyt, of Hillsboro, who resigned recently after long and faithful service with the board. The term expires March 18, 1967.

A practicing physician, specializing in obstetrics and gynecology, Dr. Ramsayer is an active participant in medical and civic affairs. He was reappointed last June to a new seven-year term on the Public Health Council, advisory group to the Ohio Department of Health. He is a past-president of the Stark County Medical Society and a delegate of his county to the OSMA House of Delegates. He has served the State Association in numerous ways and is at present a member of the OSMA Committee on Maternal Health. Among other local honors, he is president of the Stark County Historical Society and head of the local YMCA board. A few years ago he was named Canton's Man of the Year by the Chamber of Commerce.



Dr. Ramsayer

Other members of the State Medical Board are Dr. John N. McCann, Youngstown; Dr. John D. Brumbaugh, Akron; Dr. Donald F. Bowers, Columbus; Dr. Domenic A. Macedonia, Steubenville; Dr. J. O. Watson, Columbus, the osteopathic member; Dr. Melvin F. Steves, Cincinnati; and Dr. Frederick T. Merchant, Marion.

Upon the resignation of Dr. Hoyt, the Board adopted the following resolution:

"WHEREAS, W. M. HOYT, M. D., has faithfully and well performed his duties as a member of the State Medical Board for the past 26 years and

"WHEREAS, The State Medical Board of Ohio is aware of the long and faithful service, devotion, dedication and interest to the Board and to the State of Ohio as well as to the medical profession and patients, and

"WHEREAS, The State Medical Board of Ohio desires to express its gratitude to W. M. Hoyt, M. D., for his services,

"NOW BE IT RESOLVED by the State Medical Board of Ohio that the Board on behalf of itself and the State of Ohio extends its thanks and best wishes to W. M. Hoyt, M. D., for his 26 years of faithful service to the Board and to the State of Ohio."

Obituaries

Ad Astra

Everette P. Coppedge, Sr., M. D., Cleveland; Western Reserve University School of Medicine, 1908; aged 82; died December 29; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician and surgeon in Cleveland for all of his professional career, Dr. Coppedge was long associated with Woman's Hospital. Among affiliations, he was a member of the Methodist Church. Dr. Everette Peter Coppedge, Jr., his son, also is a practicing physician in Cleveland. Other survivors include his widow, two daughters and two other sons.

Ewing Herman Crawfis, M. D., Cleveland; Ohio State University College of Medicine, 1935; aged 55; died December 18 as the result of an airplane accident; member of the Ohio State Medical Association and member of the OSMA Committee on Mental Health; member of American Medical Association, the American Psychiatric Association, a member and past-president of the Ohio Psychiatric Association, member of the Central Neuropsychiatric Association. A career psychiatrist, who also held a law degree, Dr. Crawfis formerly was assistant superintendent of the Lima State Hospital and later superintendent of the Cleveland State Hospital. In 1951 he left the State to accept appointments in California and later in Arkansas. He returned to Ohio in 1956 to become head of the Fairhill Psychiatric Hospital. A 32nd Degree Mason, he is survived by his widow, two daughters, a son, a brother and a sister.

George Morris Curtis, M. D., Columbus; Rush Medical College, 1921; aged 75; died December 23; member of the Ohio State Medical Association, the American Medical Association, International College of Surgeons, American Association for the Surgery of Trauma, American College of Surgeons, American Association for Thoracic Surgery and American College of Chest Physicians. A practicing surgeon for many years in Columbus, Dr. Curtis was a prominent member of the faculty at Ohio State University College of Medicine and former chairman of the Department of Research Surgery at the University. Upon his retirement, the George M. Curtis Lecture was established at OSU in his honor. Other honors included an honorary degree of Doctor of Science bestowed by the University of Michigan, and the Government of Chile Award for his research on iodine. Among numerous contributions to medical literature, Dr. Curtis contributed several of his scientific articles to *The Journal.* Survivors include his widow, two daughters and a brother, Dr. Arthur C. Curtis, University of Michigan.

Casimir Joseph Czarnecki, M. D., Toledo; St. Louis University School of Medicine, 1922; aged 67; died December 19; member of the Ohio State Medical Association, the American Medical Association, American College of Physicians and the American Diabetes Association. A lifelong resident of Toledo, Dr. Czarnecki practiced there for some 40 years, and during World War II served overseas in the Medical Corps. A member of the Catholic Church, he is survived by his widow, four daughters, and a sister.

Harvey A. Finefrock, M. D., Barberton; University of Cincinnati College of Medicine, 1911; aged 80; died January 4; member of the Ohio State Medical Association and the American Medical Association. A native of northeast Ohio, Dr. Finefrock was in the practice of medicine for more than 50 years in the Barberton area. He was city health commissioner for 35 years and was on the board of education for 24 years. Among survivors are his widow and a son.

Samuel T. Forsythe, M. D., Cleveland; Ohio State University College of Medicine, 1913; aged 83; died January 2; member of the Ohio State Medical Association, American Medical Association and the American Academy of Ophthalmology and Otolaryngology. A practicing physician and surgeon in Cleveland for more than a half century, Dr. Forsythe specialized in ophthalmology. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in several Masonic bodies and the Rotary Club. A daughter and a brother survive.

James P. Foy, M. D., Cleveland; Indiana University School of Medicine; aged 25; died November 4 in an airplane accident. Dr. Foy was in training at the Cleveland Clinic. He and his wife were both killed while returning from the East Coast in a private plane.

Oscar Joseph Fatum, M. D., Van Wert; University of Toronto Faculty of Medicine, 1924; aged 66; died December 1; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice and the American Society of Anesthesiologists. A practicing physician in the Van Wert area for a number of years, Dr. Fatum was a past-president of the Van Wert County Medical Society. Among other affiliations he was a member of several Masonic bodies, the Elks Lodge and the Rotary Club;

also he was a veteran of World War II. Survivors include his widow, a daughter, two sons and two brothers.

Andrew Meek Gulliford, M. D., Newark; University of Pittsburgh School of Medicine, 1928; aged 60; died September 9, 1965; member of the Ohio State Medical Association and the American Medical Association. A physician in Newark, Dr. Gulliford was medical examiner for the B. & O. Railroad. Until 1957 his practice was in the area of Apollo, Pa.

Paul Ramsey Hawley, M. D., Shady Side, Md.; University of Cincinnati College of Medicine, 1914; aged 74; died December 1. Dr. Hawley's distinguished career is well known to Ohio physicians. After receiving his training at the University of Cincinnati College of Medicine, he practiced for a brief period with his father, the late Dr. William Harry Hawley, in College Corner, the Butler County community on the Ohio-Indiana border. Decorated by governments of six nations, and honored with numerous degrees, Dr. Hawley retired from the Army Medical Corps in 1946 with the rank of Major General. He subsequently held appointments with the Veterans Administration, the Blue Cross and Blue Shield Commission and the American College of Surgeons. Affiliations included memberships in numerous professional and nonprofessional organizations. His widow, a daughter and a son survive.

Edward Frederick Heffner, M. D., Wapakoneta; Medical College of Ohio, Cincinnati, 1904; aged 84; died December 19; former member of the Ohio State Medical Association and the American Medical Association; past-president of the Auglaize County Medical Society. A practicing physician for more than 60 years, Dr. Heffner served virtually all of his professional career in the Wapakoneta area, and for a time was Auglaize County coroner. Among affiliations he was a member of several Masonic bodies and the Lutheran Church. Survivors include his widow, three sons and two daughters.

Thomas Hulick, M. D., Cincinnati; Miami Medical College, Cincinnati, 1901; aged 87; died December 2; former member of the Ohio State Medical Association. A practitioner of long standing in the Evanston area of Greater Cincinnati, Dr. Hulick was retired and customarily spent the winters in Florida. He was a veteran of World War I. A daughter survives.

Harlin G. Knierim, M. D., Mansfield; Ohio State University College of Medicine, 1938; aged 52; died December 24; member of the Ohio State Medical Association, the American Medical Association, American Academy of Dermatology and Syphilology, American Academy of Facial, Plastic and Reconstruction Surgery, American Academy of Allergy, American College of Allergists and American Academy of General Practice. Dr. Knierim began his practice in Mansfield in 1941, then went into the Navy during World War II, and returned to Mansfield. He was a past-president of the Richland County Medical Society and served on numerous committees of the local organization. A member of the Seventh Day Adventist Church, he is survived by his widow, two sons and a brother.

Saul Isaac Krasne, M. D., Wickliffe; Eclectic Medical College, Cincinnati, 1936; aged 55; died November 29 in a hunting accident; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in the Wickliffe area, Dr. Krasne had only recently moved his residence to Cleveland. His widow and a child survive.

Bruno Leichtentritt, M. D., Cincinnati; medical degree from the medical faculty of Friedrich-Wil-



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References on request

helms University; aged 77; died October 14; member of the Ohio State Medical Association, the American Medical Association and the American Rheumatism Association. Born and educated in Germany, Dr. Leichtentritt practiced in that country before coming to the United States in the 1930's. A resident of Cincinnati since 1944, he held an appointment with the City Health Department and engaged in private practice, specializing in pediatrics. His widow survives.

James William Long, M. D., Bryan; Bellevue Hospital Medical College, New York, 1897; aged 94; died December 1; former member of the Ohio State Medical Association. A native of Bryan, Dr. Long served all of his professional career in that vicinity. He is survived by his widow and two daughters. (See the following obituary on his son.)

Perrin Hamilton Long, M. D., Edgartown, Mass.; University of Michigan Medical School, 1924; aged 66; died on or about December 20. A native of Bryan, where his father practiced (see above obituary) Dr. Perrin Long moved to the East Coast and specialized in research. He is credited with important contributions in the fields of the sulfa drugs.

William Hugh Miller, M. D., New Carlisle; Ohio State University College of Medicine, 1929; aged 62; died December 19; member of the Ohio State Medical Association and the American Academy of General Practice. A practicing physician in the New Carlisle area for some 30 years, Dr. Miller was physician also for the Clark County Home and during World War II directed the civilian medical program at Wright-Patterson Air Force Base. Among affiliations he was a member of the Sertoma Club and the Episcopal Church. Among survivors are his widow and three daughters.

Albert John Michels, M. D., East Liverpool; University of Pittsburgh School of Medicine, 1919; aged 71; died December 10; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A resident of long standing in the East Liverpool area, Dr. Michels practiced there more than 46 years. Among affiliations he was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow, a daughter and a son, Dr. Albert J. Michels, Jr., of the Cleveland area.

James Weaver Rae, M. D., Sylvania; Toledo Medical College, 1910; aged 85; died December 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Rae's early practice was in Bowling Green. About 1932 he helped establish the Department of Physical Medicine and Rehabilitation at Flower Hospital in Toledo and headed that service until his retirement in 1962. He was a veteran of both the Spanish-American War and World War I. Surviving are his widow, two daughters, a son, Dr. James W. Rae, Jr., of Ann Arbor, Mich.; also a brother and a sister.

David F. Schaefer, M. D., Defiance; University of Cincinnati College of Medicine, 1957; aged 33; died November 26; member of the Ohio State Medical Association and the American Medical Association. Born and reared in northwest Ohio, Dr. Schaefer returned to the vicinity in 1964 to practice. He completed an internship and residency training in Naval hospitals in the East and completed a tour with the Navy before beginning practice. A member of the Catholic Church, he is survived by his widow, four children and two sisters.

Edward H. Schoenling, M. D., Harrison; Medical College of Ohio, Cincinnati, 1900; aged 90; died August 17; former member of the Ohio State Medical Association. A general practitioner from 1900 to 1930, Dr. Schoenling became health commissioner for the Hamilton County General Health District and held that position until 1948.

Elizabeth Cisney Smith, M. D., Arlington, Mass.; Women's Medical College of Pennsylvania, 1911; aged 83; died November 13; former member of the Ohio State Medical Association. Dr. Elizabeth Smith with her husband, Dr. Augustus Edwin Smith, moved from Pennsylvania to Ohio in 1919. Both practiced in Warren until the death of the husband in 1934. She later did extensive public health work after taking advance courses in that field. Among her interests, Dr. Smith was a pioneer woman suffrage worker. Two daughters and two sons survive.

Oscar Harley Stuhlman, M. D., West Milton; Medical College of Ohio, Cincinnati, 1909; aged 82; died December 10; member of the Ohio State Medical Association and the American Medical Association. A native of Darke County, Dr. Stuhlman served all of his professional career in the west-central area of Ohio, beginning his practice at Laura, he later moved his office to East Dayton. Active in civic affairs, he was a member of several Masonic bodies and the Friends Church. Survivors include his widow, a daughter and a son, Dr. Byron C. Stuhlman, of Dayton.

Willis H. Willis, M. D., Mashaba, Southern Rhodesia; Western Reserve University School of Medicine, 1927; aged 65; died January 1; former member of the Ohio State Medical Association and the American Medical Association. A former medical missionary in Southern Rhodesia for the Congregational Church, Dr. Willis resigned his position as Lake County Health commissioner in 1959 to return to Africa. During World War II he served in the Army Medical Corps and attained the rank of lieutenant colonel. After the war he practiced medicine in Painesville before becoming full-time health commissioner. His widow, two daughters and three sons survive.

Activities of County Societies ...

First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

BUTLER

Dr. Nathan R. Abrams, director of the Arthritis Clinic in Cincinnati, was principal speaker for the November meeting of the Butler County Medical Society, where he discussed "Arthritis in Children." Dr. Abrams also is associate clinical professor of medicine at the University of Cincinnati College of Medicine.

The program was jointly sponsored by the Ohio Valley Chapter of the Arthritis Foundation.

HAMILTON

"Treatment of Shock" was the topic of discussion for the January 18 meeting of the Academy of Medicine of Cincinnati in the academy building.

Participating in the panel, as indicated on the advance program, were the following physicians:

Dr. Thomas Gaffney, assistant professor of medicine and director of the Division of Clinical Pharmacology, University of Cincinnati College of Medicine.

Dr. F. A. Simeone, professor of surgery, Western Reserve University School of Medicine, Cleveland, and

Dr. Richard C. Lillehei, associate professor of surgery, University of Minnesota School of Medicine.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

MONTGOMERY

The Montgomery County Medical Society's 117th Annual Presidential Inaugural program was held on January 14 at the Sheraton Dayton Hotel. A reception and dinner was held for members, their wives and guests.

Installed as 1966 president, Dr. Charles E. O'Brien delivered the president's address. Other officers are Dr. William J. Lewis, president-elect; Dr. Peter A. Granson, vice-president; Dr. Albert B. Huffer, secretary; and Dr. Don E. Sando, treasurer. Dr. Mason S. Jones is the immediate past-president.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The January program of the Academy of Medicine of Toledo and Lucas County included the following features:

January 12 — 64th Annual Academy Meeting; guest speaker, Dr. Nicholas P. Dallis, "The Mode of American Medicine."

January 19 — Dr. Peter P. Bosomworth, professor of medicine, University of Kentucky, "Prevention and Management of Pulmonary Complications Associated with Long-term Mechanical Ventilation." The program was sponsored by the Toledo Society of Anesthesiology.

SANDUSKY

The Sandusky County Medical Society and Auxiliary held the regular Christmas party in the Hotel Fremont, Fremont, on December 14. Donations were accepted for the work of the King's Daughters.

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland and the Heart Association of Northeastern Ohio sponsored a seminar on "Rheumatic Fever in Cleveland—1966," at the Academy auditorium on January 5.

Among guest speakers were Dr. Richard Krause, St. Louis, and Dr. Allan C. Siegal, Chicago. Local



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speakers included Dr. E. A. Mortimer, Jr., and Dr. Charles H. Rammelkamp, Jr.

The Cleveland Academy is sponsoring the Academy of Medicine Radio Roundtable, weekly Sunday evening broadcasts over Station WGAR entitled, "The Doctor Speaks."

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

STARK

Dr. A. R. Furnas, Jr. of Massillon was installed as president of the Stark County Medical Society at the annual meeting held Thursday evening (Dec. 16) in Mergus Garden Room. He succeeds Dr. Harold J. Bowman. Designated as president-elect for 1967 is Dr. Murray W. Scott, Jr. of Canton. The secretary-treasurer for the coming year is Dr. Mark F. Moots. Dr. Mark G. Herbst was named delegate and Dr. Richard Skibbens alternate delegate to the State Association.

Serving on the Board of Censors for the next year are Dr. Gerry I. Newman, Dr. C. V. Smith, Dr. William D. Baker, Dr. Bowman, Dr. Furnas, Dr. Scott and Dr. Moots.

Special honors were bestowed on three physicians who have been in the practice of medicine for more than 50 years: Dr. H. S. Myers of Massillon, Dr. C. J. Schirack of Canton and Dr. Loren L. Frick of North Canton.

Dr. Myers is a graduate of Western Reserve University Medical School and following two years of service in World War I, began his practice in Navarre. Six years later he moved to Massillon and has served that community since.

Dr. Schirack received his training at Eclectic Medical College in Cincinnati and except for wartime military service has practiced his entire 50 years in Canton.

Dr. Frick is a graduate of Ohio State Medical School and has spent his entire career in practice in North Canton and Canton, except for military service in France during World War I.

TUSCARAWAS

The Tuscarawas County Medical Society with the Auxiliary held its annual Christmas party at the Union Country Club. A feature of the program was an auction of articles made mostly by members of the Auxiliary, with Dr. James Houglan as auctioneer. Proceeds of the auction go to the AMA-ERF.

TRUMBULL

The Trumbull County Medical Society with the Auxiliary held its annual holiday season dinner dance on December 15 at the Trumbull County Country Club.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

LORAIN

New officers for 1966 were installed on December 14, when 101 members of Lorain County Medical Society, including their wives, met at Oberlin Inn for the annual meeting. They took office as of January 1.

Joseph A. Cicerrella, M. D., of Lorain, succeeded John W. Wherry, M. D., of Elyria, as president. The role of secretary-treasurer was assumed by John B. McCoy, M. D., Elyria, for a two-year term, and the president-elect for 1967 is Robert S. VanDervort, M. D., Elyria. Installed as vice-president was Bristow C. Myers, M. D., of Lorain, and Charles C. Butrey, M. D., Lorain, serves as a censor for a three-year term, replacing H. C. Marsico, M. D., Lorain, whose term expired.

Delegates to Ohio State Medical Association for a two-year term are Ben V. Myers, M. D., Elyria, and James T. Stephens, M. D., Oberlin, who continue for another term in office. Named Alternate Delegates are William H. Miller, M. D., Elyria, and Max L. Durfee, M. D., Oberlin.

The new President, Dr. Cicerrella, received his M. D. Degree from St. Louis University, Mo., and has been a member of Lorain County Medical Society, Ohio State Medical Association and American Medical Association since 1946. His specialty is pediatrics.

A standing vote of thanks for their successful term of office was accorded to outgoing officers President John W. Wherry, M. D., and William H. Miller, M. D., who has served in the capacity of secretary-treasurer for the last three years. Continuing

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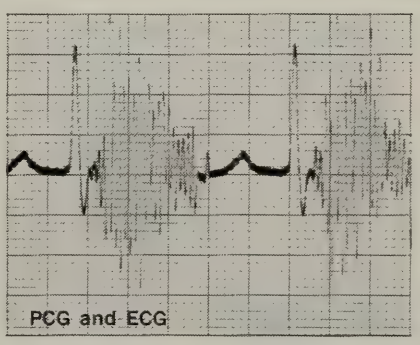
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in office as censors are Drs. Harold E. McDonald, Elyria, and William E. Kishman of Lorain.

Preceding the Installation of officers was a social hour and dinner at the Inn. Lawrence C. Meredith, M. D., Elyria, President-Elect of the State Organization, addressed the audience and outlined the role of the individual physician and the medical profession as a whole, in their future endeavors to eliminate deterioration of medical care. The Women's Auxiliary retired to the Red Rooms to conduct its business affairs as the annual meeting of Lorain County Medical Society continued. Corespondence was read from 11th District Councilor William R. Schultz, M. D., who was unable to attend. Kenneth O'Connor, M. D., Elyria, was unanimously elected to Active Membership in the Society, and a first reading was given to the application of Ibrahim Eren, M. D., of Lorain.

Two Resolutions were read and passed unanimously for transmittal to Council of OSMA.

Committee reports were heard from Chairmen of the committees as follows: Public Relations, R. S. VanDervort; Education and Medical Symposium, Max L. Durfee; Mediations, Bristow C. Myers; School Health, Andrew M. Mattey; Cancer, A. Clair Siddall; Blood Bank, Stanley J. Birkbeck; Insurance, George W. Bennett; Resident Training, Roy E. Hayes; Medical Foundation, Roy E. Hayes; Liaison with Health Professions, Maynard J. Brucker; Legislative and "Operation Hometown," R. L. Shilling.

Following announcement of future programs and seminars, President John W. Wherry, M. D., reported on the activities and interests of the Society throughout 1965 and thanked all the members who had assisted him during his term of office. Secretary-Treasurer William H. Miller, M. D., presented the financial report and the budget for 1966, together with data on the membership and various meetings held throughout the year. The Nominating Committee's report was unanimously accepted and installation of officers for 1966 proceeded.

Dr. Cicerrella's response as newly installed President outlined the further aims and endeavors of the Society in 1966.

* * *

President Joseph A. Cicerrella, M. D., welcomed a total audience of 50 at the regular meeting of Lorain County Medical Society at Oberlin Inn on January 11. Business included the election of Ibrahim N. Eren, M. D., of Lorain, to Associate Membership in the Society, and the reading of a Resolution which was unanimously approved for submission to Ohio State Medical Association for presentation at the Annual Meeting in May of 1966.

Featured speaker of the evening was George G. Goler, M. D., of Cleveland. An OB-Gyn Specialist, Dr. Goler recently served a tour of duty aboard the S. S. HOPE in Conakry, Guinea, West Africa. With slide presentations, he outlined Project HOPE's efforts toward world good will and international friendship and emphasized the diplomatic accomplishments of this ship, together with the training of local personnel in efforts to alleviate the crippling ill health in underdeveloped countries.

An informative question and answer period following the program stressed the value of individual and personal commitment to such a project as HOPE. The color film "HOPE in Peru" was also shown to the audience.

MEDINA

The Medina County Medical Society held its annual Christmas dinner dance at the Rustic Hills Country Club in mid-December.

Dr. Louis Rakita, associate professor of medicine at Western Reserve University School of Medicine, will be a member of the guest faculty when the American College of Physicians holds Postgraduate Course No. 13 in Houston, Texas. Subject for the course at Baylor University College of Medicine, March 7-11, is "The Big Heart."

Dr. Francis W. Logan, Delaware, and his wife are serving tours with the Peace Corps in Iran.

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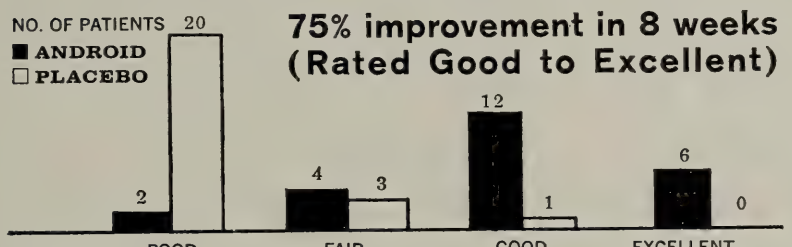
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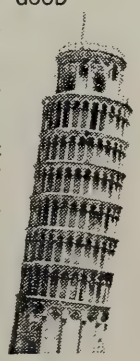
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2. *Methyltestosterone-Thyroid in Treating Impotence*. A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
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Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee
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CHAIRMANWISE, there is no more important job on the State Board in these days of the Great Society than that of the Legislation chairman. She has to keep up with the raft of bills passed, proposed and being dreamed up. She has to keep in direct touch with the Legislation Committee of the Ohio State Medical Association and with the American Medical Association to become knowledgeable on the parent organization's attitudes toward these bills. If anyone can do this and do it successfully, it is Mrs. Harry L. Fry of Cincinnati, the incumbent chairman, who takes her job seriously and gives it all she's got. She has spent, and is spending, innumerable hours, days and weeks compiling essential data and she wants to share her information with the county auxiliaries.

To that end, she made a courageous announcement at the recent mid-winter State Board meeting: she is willing to go anywhere, any time, to any county auxiliary, to bring local groups the vital information they should have. There is a most significant election coming up this November and the time to begin laying the groundwork is NOW — not in the last frantic weeks before Election Day. There is so much we need to know — what we can do — what we cannot do. We even need to know about such things as the cruel hoax being played by con men on elderly people: despicable characters who go from door to door collecting the three dollar voluntary insurance payments. Have you heard about PREVENTACARE which is said to be the next possible piece of medical legislation that will be introduced? Most important, do you understand fully the import of OMPAC — the medical association's Political Action Committee?

If Frankie Fry is willing to give of her time and energies to bring each of you her message directly, it would seem to go without saying that every local group should be deeply grateful and anxious to avail itself of this unusual opportunity. Mrs. Fry hopes she can come up with a well-trained Speakers' Bureau one of these days, but in the meantime, **she is at your service.** There is no more vital project on which doctors' wives can work than this matter of legislation. Prove your interest and dedication by contacting Mrs. Harry Fry, Apartment 1804, at 1071 Celestial Street, Cincinnati 45202, telephone 421-3595. Not so incidentally, if you haven't had the privilege of hearing Mrs. Fry, take it from this reporter that there is no more dynamic, forceful or interesting a speaker than this charming woman who heads our State Legislation Committee.

Two More Chairmen Speak

Mrs. Max T. Schnitker, International Health chairman, wants to call attention to the new address of the World Medical Relief Organization in Detroit, Michigan: 11745 - 12th Street. The telephone number is 866-5333 and the zip code for Detroit is 48201. She hopes everyone is remembering about those drug samples, etc., and she further urges continued financial (and badly needed!) support of Project Hope.

From our AMA-ERF chairman, Mrs. R. K. Ramsayer, comes the word that as of January 8, contributions were in the amount of $20,665.13. While these figures show an increase over the same period last year, we still have a long way to go (if we hope to stand a chance of winning a national award). Not that that is the incentive, of course. Maximum support of the outstanding work of AMA-ERF is what counts. But it would be nice (a fringe benefit, sort of!) to nose out California for a change! Remember to make your checks out to the AMA-ERF Auxiliary

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Now — The Counties

Discussing new educational trends for the **Allen County** group at Hampshire House recently was Dr. Lloyd Ramseyer, emeritus president of Bluffton College. Guests of the auxiliary were pharmacists' wives. Dr. Ramseyer spoke of the population explosion, ever-increasing automation and competitive pressures. Current emphasis, the speaker added, is concentration on fewer subjects, better utilization of facilities, audio-visual aids and more diversified curricula to accommodate all student types. Hosting the luncheon for the 60 members and guests were Mrs. B. W. Travis, Mrs. W. C. Berry, Mrs. Theophile Andjus, Mrs. J. D. Albertson, Mrs. T. D. Allison, Mrs. J. F. Tillotson, Mrs. H. C. Weisenbarger, Mrs. W. T. Wright and Mrs. R. S. Sobocinski.

Something new for the **Hamilton Auxiliary** was on the calendar in January. Instead of the usual luncheon meeting that brings the membership together at a central spot, 13 "coffees" were held simultaneously in the homes of members in various sections of the city. The idea was conceived by the group's president, Mrs. John B. Toepfer, as a means of promoting fellowship among the organization's 600 members in a smaller, more informal setting and the gatherings this time were entirely social to permit members to get to know each other better.

Mrs. Don Aicholz and Mrs. Richard Wendel were general chairmen for the day and issued the invitations to the specific homes. A representative of the executive board was present at each get-together. The homes at which this unusual event took place included those of: Mrs. William A. Altemeier, Mrs. James Gray, Jr., Mrs. Robert L. Coith, Mrs. John M. Glenn, Mrs. Robert S. Heidt, Mrs. Ken W. Rahe, Mrs. Neal M. Earley, Mrs. Daniel E. Earley, Mrs. James D. Phinney, Mrs. Robert H. Preston, Mrs. Howard Pfister, Mrs. Ogden H. Baumes and Mrs. William P. Jennings.

A recent outstanding display and feature story in the *Cincinnati Enquirer* deserves recognition. "Apple Tree Bears Fruit for Hospitals" was the headline and it was doubly significant because of a front page story in that very edition telling of the nurse shortage at Cincinnati General Hospital and the subsequent forced cutting of certain hospital service. Those of you who read the story on the Apple Tree in this column will recall the purpose of it all was to do something about the shortage of registered nurses and other essential personnel in Cincinnati hospitals. The auxiliary project is a day-care center where such personnel can leave their children while they work.

The Help of Music

January was "Music Month" for the **Lucas County** auxiliary "Morning Coffee Concerts," annual events, benefit the Citizens' Day Care project in its outstanding program for Toledo school children. Each morning concert took place on a different day of the week. (Lucas and Hamilton certainly put coffee to work for them, wouldn't you say?) Mary Nelson and Shirley Roe performed as duo-pianists at the home of Mrs. John Erler; at the home of Mrs. L. D. Fruchtman, singers from the Toledo Opera Association featured the program; Mrs. Kermit Meinert's residence resounded to the strains of Highlights of Broadway Shows; the Tolora Quartet performed at the home of Mrs. Glenn Usher; Mrs. Robert Wolfe's musician guests included a soloist, pianists, violinist and clarinetist; and at the Ottawa Hills High School, the Toledo Ballet performed the "New York World's Fair Program."

Even the January luncheon meeting of the Lucas women featured a musical program given by one of its own members, Mrs. Robert Hauman, who was the Grinnell Opera Scholarship winner for 1965. The Finance Study Group also got under way in January. The hostess was Mrs. Everett Kasher and the topic was "Services of the Bank" presented by Mrs. Claude May of the public relations department of the Toledo Trust Company. A second Finance Study group program in January was on "Life Insurance and Financial Security." An interesting sidelight — the Lucas group had its own "Woman's Auxiliary" page in

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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the December Academy Bulletin, edited by Betty Jenkins. I don't know if this is a regular monthly feature or not, but it certainly is a fine idea and opportunity.

Trumbull County auxiliary received excellent newspaper coverage on its Health Career Day project. Members held conducted tours at St. Joseph and Trumbull Memorial Hospitals in Warren for interested students from the area high schools. The group's rural chairman has come up with a poster campaign to encourage immunizations. The safety and disaster control chairman is busy with "Good Emergency Mothers," a training course for baby sitters. The mental health chairman works in close cooperation with the director of the Trumbull County Guidance Center. Sorry I can't give you the names of these wonderful women, but they just weren't mentioned in the material sent me.

Help Wanted!

Help wanted from all you local publicity chairmen, that is . . . You've been so good for so many months now about sending me clippings (at least, most of you have) but suddenly there's a lull and that's bad for my business — and yours! How can I report local auxiliary activities if I'm not kept informed?? So please — get those clippings, reports or what have you headed my way — right away!

Diseases of the Colon, One Of Courses at OSU

On Wednesday, February 23, Ohio State University College of Medicine is offering a short course for physicians entitled "Diseases of the Colon." Registration opens at 8:00 a. m. with the program starting at 8:30.

Guest speaker will be Dr. Harold P. Roth, director of the gastroenterology program at Western Reserve University School of Medicine, and chief of the gastroenterology service at the Veterans Administration Hospital, Cleveland.

Other faculty members will be from the various services at Ohio State University — medicine, gastroenterology, radiology, surgery, and pathology.

Additional information on this and other courses may be obtained by contacting The Center for Continuing Medical Education, 320 West Tenth Avenue, Columbus 43210.

Other OSU courses scheduled in the near future include the following:

Ninth Annual Postgraduate Course in Ophthalmology, March 7, 8.

Pediatric Invitational Clinic, March 16.

Lederle Symposium, March 27.

Seventh Annual Pediatric PG Course, March 31 - April 2.

Carroll County Medical Society Announces Medical Seminar

On Wednesday, April 13, the Carroll County Medical Society will sponsor its Second Annual Postgraduate Medical Seminar at the Atwood Yacht Club, Atwood Lake, Route 1, Dellroy, across from the new Atwood Lodge.

Faculty will be a team from the University of Cincinnati College of Medicine, with two internists, one surgeon and one psychiatrist participating. There also will be a ladies program, and all physicians and their wives of the area are invited. Category I continuation study credit of the American Academy of General Practice has been applied for.

Dr. Thomas J. Atchison, 292 East Main Street, Carrollton, is secretary of the Society.

Medical Ethics Essay Contest Open to Medical Students

The American Medical Association, through the Judicial Council, is sponsoring a Medical Ethics Essay Contest for the academic year 1965-1966. The contest is a part of the Judicial Council's Expanded Program on Medical Ethics.

The contest is being named in honor of the late Norman A. Welch, M. D., who died September 3, 1964, while serving as the 118th President of the American Medical Association. The contest is open to junior and senior students in any accredited medical school in the United States.

Cash prizes totaling $1,000 will be awarded for the winning essays. First prize will be $500; second prize $300; and third prize $200.

Lists of suggested topics will be available from the AMA. Deadline for entries this year is June 1.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during December. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

Columbiana
Ranulfo V. Gracilla, Salem

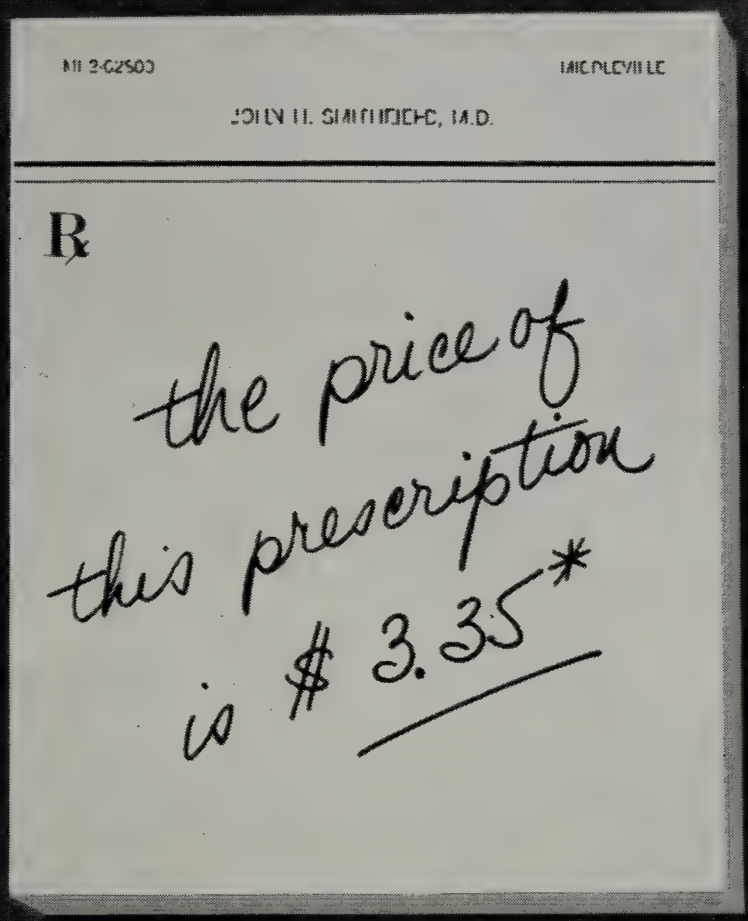
Cuyahoga
Pete N. Poolos, Jr., Cleveland

Franklin
Calvin B. Early, Columbus

Hamilton
Daniel J. Kindel, III, Cincinnati
John D. Pottschmidt, Cincinnati
David Van Ginkel, Cincinnati

Lucas
Paul J. Raglow, Toledo

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First District, Robert E. Howard, 2600 Union Central Bldg., Cincinnati 45202; **Second District,** Theodore L. Light, 2670 Salem Ave., Dayton 45406; **Third District,** Frederick T. Merchant, 1051 Harding Memorial Pky., Marion 43305; **Fourth District,** Robert N. Smith, 3939 Monroe St., Toledo 43606; **Fifth District,** P. John Robechek, 10525 Carnegie Ave., Cleveland 44106; **Sixth District,** Edwin R. Westbrook, 438 North Park Ave., Warren; **Seventh District,** Benj. C. Diefenbach, 30 S. 4th St., Martins Ferry; **Eighth District,** Robert C. Beardsley, 2236 Maple Ave., Zanesville; **Ninth District,** George N. Spears, 2213 So. Ninth St., Ironton; **Tenth District,** Richard L. Fulton, 1211 Dublin Rd., Columbus 43212; **Eleventh District,** William R. Schultz, 1749 Cleveland Rd., Wooster 44691.

COMMITTEES

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Committee on Occupational Health—Rex H. Wilson, Akron, Chairman; Drew J. Arnold, Columbus; William W. Davis, Columbus; Winfred M. Dowlin, Canton; Harold M. James, Dayton; H. W. Lawrence, Middletown; Daniel M. Murphy, Marion; Anthony M. Puleo, Cleveland; George W. Wright, Cleveland; H. P. Worstell, Columbus.

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Committee on Rural Health—Robert E. Reiheld, Orrville, Chairman; Chester J. Brian, Eaton; J. Martin Byers, Greenfield; Walter A. Campbell, Coshocton; E. Joel Davis, East Canton; Victor R. Frederick, Urbana; Benjamin W. Gilliotte, Zanesville; Jerry L. Hammon, West Milton; Jasper M. Hedges, Circleville; Luther W. High, Millersburg; E. D. Mattmiller, Athens; John R. Polsley, North Lewisburg; Leonard S. Pritchard, Columbiana; Harold C. Smith, Van Wert; Kenneth W. Taylor, Pickerington; Edmond K. Yantes, Wilmington.

Committee on Scientific and Educational Exhibit—Charles V. Meckstroth, Columbus, Chairman; Harvey C. Knowles, Jr., Cincinnati; W. Arnold McAlpine, Toledo; Arthur E. Rappoport, Youngstown; Arnold M. Weissler, Columbus; Walter J. Zeiter, Cleveland; Robert E. Zipf, Dayton.

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Committee on Traffic Safety—N. J. Giannestras, Cincinnati, Chairman; Howard W. Brettell, Steubenville; Drew L. Davies, Columbus; Clark M. Dougherty, New Philadelphia; Wesley L. Furste, Columbus; Thomas W. Morgan, Gallipolis; Lester G. Parker, Sandusky; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus; John F. Tillotson, Lima; Robert C. Waltz, Cleveland; Paul L. Weygandt, Akron; Robert E. Zipf, Dayton.

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OSMA Members of the Joint Committee on School Bus Driver Examinations—Carey B. Paul, Jr., Columbus; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus.

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES

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Councilor: Robert E. Howard, Cincinnati 45202
2600 Union Central Bldg.

ADAMS—Gary J. Greenlee, President, Manchester 45144; Stanley H. Title, Secretary, Manchester 45144.

BROWN—John A. Powell, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown. 3rd Sunday, monthly.

BUTLER—Robert Johnson, President, 500 S. Breiel Boulevard, Middletown 45042; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 4th Wednesday monthly.

CLERMONT—Cecil F. Barber, President, State Route 133, Felicity 45120; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond 45157. 3rd Wednesday monthly, except July and August.

CLINTON—Richard R. Buchanan, President, 115 West Main, Wilmington 45177; Mary Ranz Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Robert M. Woolford, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Monthly meeting dates, 1st Tuesday; Academy, 3rd Tuesday, except June, July and August.

HIGHLAND—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

WARREN—O. Williard Hoffman, President, 20 East Fourth Street, Franklin 45005; Ray E. Simendinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: Theodore L. Light, Dayton 45406
2670 Salem Ave.

CHAMPAIGN—Myron J. Towle, President, 848 Scioto Street, Urbana 43078; Fred R. Denkewalter, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—Henry M. Tardif, President, 2608 E. High Street, Springfield 45505; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield 44501. 3rd Monday monthly, except June, July and August.

DARKE—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, South West St., Versailles. 3rd Tuesday, monthly.

GREENE—Clement G. Austria, President, 1142 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly except July and August.

MIAMI—David Brown, President, 1060 North Market Street, Troy 45373; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua 45356. 1st Tuesday monthly.

MONTGOMERY—Charles E. O'Brien, President, 600 Fidelity Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly October through May — 1st Wednesday June.

PREBLE—W. C. Clark, Jr., President, 228 N. Barron St., Eaton: John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

SHELBY—George J. Schroer, President, 322 Second Ave., Sidney; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney.

Third District

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1051 Harding Memorial Pky.

ALLEN—Carl H. Zinsmeister, President, 729 W. Market Street, Lima 45801; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly.

AUGLAIZE—Robert Sobocinski, President, 75 Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring Street, St. Marys 45885. 1st Thursday monthly except July.

CRAWFORD—Don E. Ingham, President, 201 N. Market Street, Galion 44833; Johnson H. Chow, Secretary, 1040 Devonwood Drive, Galion 44833. Called meetings.

HANCOCK—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.

HARDIN—William D. Dewar, President, 405 North Main Street, Kenton 43326; John J. Roget, Secretary, Belle Center 43310. 2nd Tuesday monthly.

LOGAN—Thomas Seitz, President, 223 E. Columbus Street, Bellefontaine 43311; Glen Miller, Secretary, R. D. 2, West Liberty 43357. 1st Friday monthly.

MARION—Ransome Williams, President, 1035 Harding Memorial Parkway, Marion 43302; Alice Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—R. Duane Bradrick, President, Rockford 45882. 3rd Thursday monthly. (Secretary not definite as of December 10, 1965.)

SENECA—Olgierd C. Garlo, President, 53 Clay Street, Tiffin 44883; Leonard M. Gaydos, Secretary, 233 South Monroe Street, Tiffin 44883. 3rd Tuesday monthly.

VAN WERT—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.

WYANDOT—Franklin M. Smith, President, E. Saffle Ave., Box 68, Sycamore; Robert E. Goyne, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—L. F. Berry, Jr., President, 1400 East Second Street, Defiance 43512; W. S. Busteed, Secretary, Box 218, Defiance 43512.

FULTON—B. H. Reed, Jr., President, Delta 43515; R. L. Davis, Secretary, Wauseon 43567. 2nd Tuesday quarterly March, June, September, December.

HENRY—J. J. Harrison, President, 113 East Clinton Street, Napoleon 43545; Gamble S. Hall, Secretary, 834 Strong Street, Napoleon 43545. 1st Tuesday monthly.

LUCAS—R. Philip Whitehead, President, 424 W. Woodruff Ave., Toledo 43602; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday.

OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.

PAULDING—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.

PUTNAM—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Lugibihl, Secretary, Pandora. 1st Tuesday monthly.

SANDUSKY—J. L. Zimmerman, President, Memorial Hospital of Sandusky County, Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.
WILLIAMS—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.
WOOD—Roger A. Peatee, President, 140 S. Prospect Street, Bowling Green 43402; William B. Elderbrock, Secretary, Health Service, Bowling Green State University, Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44106
10525 Carnegie Ave.

ASHTABULA—J. R. Nolan, President, 2736 Lake Avenue, Ashtabula 44004; Richard Millberg, Secretary, 430 West 25th Street, Ashtabula 44004. 2nd Tuesday monthly.
CUYAHOGA—William F. Boukalik, President, 20030 Scottsdale Boulevard, Cleveland 44122; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.
GEAUGA—Bruce F. Andreas, President, 400 Downing Drive, Chardon 44024; Arturo J. Dimaculangan, Secretary, 8400 Mayfield Road, P. O. Box 277, Chesterland 44026. 2nd Friday monthly.
LAKE—Robert W. Colopy, President, 89 E. High Street, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening monthly, January, May, March, September and November unless otherwise ordered by Council.

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

COLUMBIANA—Peter Cibula, President, 356 E. Lincoln Way, Lisbon; Ernst P. Schaefer, Secretary, 412 N. Lincoln Ave., Salem. 3rd Tuesday, monthly.
MAHONING —F. A. Resch, President, Doctors Park, Canfield 44406; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly except July and August.
PORTAGE—David Palmstrom, President, 124 North Prospect Street, Ravenna 44266; William R. Brinker, Secretary, 141 East Main Street, Kent 44240. 3rd Tuesday monthly.
STARK—A. R. Furnas, Jr., President, 420 Lake Avenue, N. E., Massillon 44646; Mr. John H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.
SUMMIT—James G. Roberts, President, 655 West Market Street, Akron 44303; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, 159 South Main Street, Akron 44308. 1st Tuesday monthly.
TRUMBULL—John F. McGreevey, President, 297 Hawthorne Lane N. E., Warren 44484; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly September through May.

Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry 43935
30 S. 4th St.

BELMONT—James Sutherland, President, 9 North 4th Street, Martins Ferry 43935; Bertha M. Joseph, Secretary, 100 South 4th Street, Martins Ferry 43935. 3rd Thursday of February, March, April, June, September, October, November and December.
CARROLL—Glen C. Dowell, President, 207 West Main, Carrollton 44615; Thomas J. Atchison, Secretary, 292 East Main, Carrollton 44615. 1st Thursday monthly.
COSHOCTON—Don Warren, President, 600 East Main Street, West Lafayette 43845; Harold Lear, Secretary, 133 South Fourth Street, Coshocton 43812. 2nd Tuesday monthly.
HARRISON—Charles D. Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988, Quarterly.
JEFFERSON—Jacob R. Cohen, President, 341 Market Street, Steubenville 43952; Irving Dreyer, Secretary, P. O. Box 308, Steubenville 43952. 4th Tuesday monthly except December, January, February.
MONROE—Byron Gillespie, Secretary, S. Main St., Woodsfield.
TUSCARAWAS—S. H. Winston, President, 658 Boulevard, Dover; G. W. Johnston, Secretary, 658 Boulevard, Dover. 2nd Thursday, monthly.

Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705
2236 Maple Ave.

ATHENS—D. R. Johnson, President, 52 West Washington Street, Nelsonville 45764; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday monthly except July and August.
FAIRFIELD—George W. LeSar, President, 216 Harmon Avenue, Lancaster 43130; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore 43105. 2nd Tuesday monthly.
GUERNSEY—A. C. Smith, President, 1115 Clark Street, Cambridge 43725; Dayle O. Snyder, Secretary, 840 Wheeling Avenue, Cambridge 43725. 1st Tuesday monthly.
LICKING—Carl L. Petersilge, President, 104 Hudson Avenue, Newark 43055; Robert P. Raker, Secretary, 317 N. Granger Street, Granville 43023. 4th Tuesday monthly.
MORGAN—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, Box 199, Malta 43758.
MUSKINGUM—Paul A. Jones, President, 838 Market Street, Zanesville 43701; Myron Powelson, Secretary, 2825 Maple Avenue, Zanesville 43705. 2nd Tuesday monthly.
NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, 415 Main Street, Caldwell 43724. 1st Tuesday monthly.
PERRY—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.
WASHINGTON—Donald Fleming, President, Vincent; Archbold M. Jones, Jr., Secretary, 326 Third St., Marietta.

Ninth District

Councilor: George N. Spears, Ironton 45638
2213 S. 9th St.

GALLIA—Quentin Korfhage, President, Gallipolis Clinic, Gallipolis 45631; John Groth, Secretary, Holzer Clinic, Gallipolis 45631. Monthly meetings at called times.
HOCKING—Jan S. Matthews, President, 9 East Second Street, Logan 43138; H. M. Boocks, Secretary, Route 3, Logan 43138. 2nd Tuesday monthly.
JACKSON—A. R. Hambrick, President, Wellston; John C. MacLennan, Secretary, Oak Hill. Meeting date varies.
LAWRENCE—Frank W. Crowe, President, 2110 South 9th Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly at called times.
MEIGS—Selim J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once monthly.
PIKE—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.
SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Erich Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. 2nd Monday in February, April and October; December meeting and summer meeting decided by the Council and members notified one month in advance.
VINTON—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

Tenth District

Councilor: Richard L. Fulton, Columbus 43212
1211 Dublin Rd.

DELAWARE—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.
FAYETTE—R. D. Woodmansee, President, 403 East Market Street, Washington C. H. 43160; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday monthly
FRANKLIN—Joseph A. Bonta, President, 3100 Olentangy River Road, Columbus 43202; Mr. W. "Bill" Webb, Jr., Executive Secretary, 79 East State Street, Room 601, Columbus 43215. 3rd Tuesday monthly.
KNOX—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.
MADISON—Sol Maggied, President, 15 East Pearl Street, West Jefferson 43162; Michael Meftah, Secretary, 11 East 2nd Street, London 43140. 1st Wednesday monthly.
MORROW—Francis W. Kubb, President, 140 North Main, Mt. Gilead 43338; William S. Deffinger, Secretary, Box 8, Marengo 43334. 1st Tuesday monthly.
PICKAWAY—V. D. Kerns, President, 143 E. Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney Street, Circleville 43113. 1st Friday evening monthly, except months of July and August.
ROSS—Joseph McKell, President, 174 W. Main Street, Chillicothe 45601; Lowell O. Smith, Secretary, 217 Delano Avenue, Chillicothe 45602. 1st Thursday evening monthly.
UNION—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Road

ASHLAND—Henry C. Chalfant, President, 309 Arthur Street, Ashland 44805; H. W. Smith, Secretary, 414 Samaritan Avenue, Ashland 44805. 1st Thursday monthly.
ERIE—Clinton F. Lavender, President, 1218 Cleveland Road, Sandusky 44870; R. D. Gillette, Secretary, P. O. Box 127, Huron 44839. Alternate Tuesday and Thursday monthly.
HOLMES—Charles H. Hart, President, 109 South Clay Street, Millersburg 44654; William A. Powell, Secretary, 8 West Adams Street, Millersburg 44654. Monthly meeting date to be determined later.
HURON—W. R. Graham, President, 15 Main Street, Wakeman 44889; E. R. McLoney, Secretary, 257 Benedict Avenue, Norwalk 44857. 2nd Wednesday of February, April, June, August, October, and December.
LORAIN—Joseph A. Cicerrella, President, 209 6th Street, Lorain 44052; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly except June, July and August.
MEDINA—Myrl A. Nafziger, President, Albrecht Building, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina, Ohio 44256. 3rd Thursday monthly.
RICHLAND—C. J. Shamess, President, 74 Wood Street, Mansfield 44903; Harold F. Mills, Secretary, 70 Madison Road, Mansfield 44905. 3rd Thursday monthly except June, July and August.
WAYNE—Howard MacMillan, President, 1740 Cleveland Road, Wooster 44691; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday monthly, January, February, April, September, November and December.

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Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
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The
OHIO STATE MEDICAL
Journal

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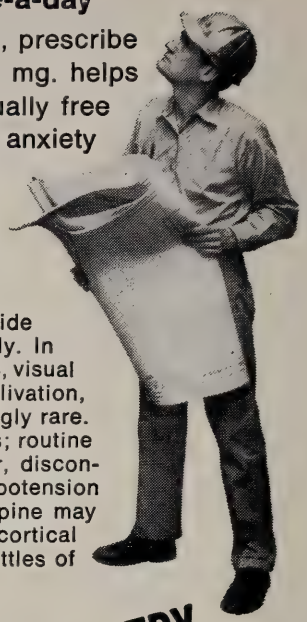
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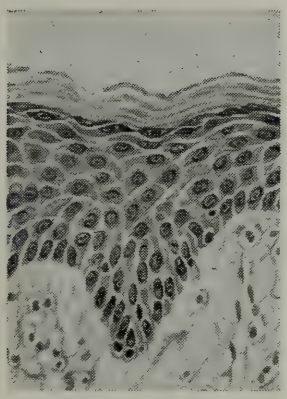
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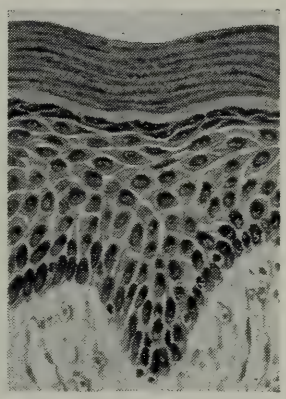
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Letter To The Editor

December 22, 1965

Dr. Perry R. Ayres, Editor
The Ohio State Medical Journal
79 East State Street
Columbus, Ohio 43215

Dear Dr. Ayres:

The article by Dr. Jackson Blair [*Ohio State Med. J.*, 61:732-734 (August) 1965] presents an interesting hypothesis which relates coronary disease with the ingestion of mustard. This hypothesis is based on uncontrolled observations in a series of patients, a laboratory study which showed the development of statistically significant hypertension in rats maintained on a mustard diet, and an unsubstantiated statement reported in an abstract which relates hypertension in rats with allyl isothiocyanate, a component of mustard.

Black mustard, *Brassica nigra,* contains a glucoside which yields allyl isothiocyanate on hydrolysis. Guenther *(The Essential Oils,* Vol. II, New York: Van Nostrand, 1949, pp. 734-737, 742) states that this pungent oil is widely used as flavoring in mustards and table sauces. White mustard, *Brassica alba,* contains a glycoside which yields p-hydroxy benzyl isothiocyanate on hydrolysis. Both the volatile allyl isothiocyanate and the non-volatile p-hydroxy benzyl isothiocyanate are vesicants (Guenther).

A detailed evaluation of the methods, data, and reasoning contained in the article by Dr. Blair will not contribute to the verification or rejection of the hypothesis. The individual scientist must decide whether the data are sufficient to support a reasonable hypothesis. If the hypothesis is reasonable it can be verified by repeating the experiments, confirming the observations, and completing a detailed laboratory investigation. It is apparent that Dr. Blair wrote this article in the hope that it would stimulate further study. I am convinced that further study would be stimulated most effectively by additional laboratory data.

Sincerely yours,
(Signed) David G. Cornwell
Professor and Chairman
Department of Physiological Chemistry
The Ohio State University

EDITOR'S NOTE: This letter of evaluation was written by Dr. Cornwell at our request. — P.R.A.

The success of immunization against poliomyelitis is reflected in the extremely low number of deaths and cases reported in 1965. Only about 60 cases were reported in the United States during the year. This compares with nearly 29,000 cases reported in 1955, about the time that the Salk vaccine was introduced. — *Metropolitan Life.*

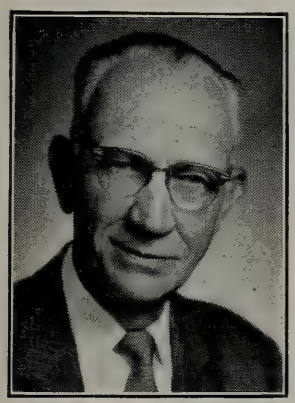


This tablet has earned "...the greatest clinical acceptance"[1] of any long-acting coronary vasodilator

Medical Executive of Long Standing In the Columbus Area Dies

Stanley R. Mauck, former executive secretary of the Academy of Medicine of Columbus and Franklin County and founder of the Columbus Bureau of Medical Economics, died on February 5 at the age of 72.

Mr. Mauck was executive secretary of the Columbus Academy, on a part-time basis, from 1935 to 1957, and during much of that time was also part-time executive secretary for the Columbus Dental Society. In 1935 also he established the Columbus Bureau of Medical Economics, and in 1948 organized the Central Answering Service, Inc., in Columbus.



Stanley R. Mauck

His community services included memberships in the following organizations and groups: Family and Children's Bureau, of which he was a past-president; Community Chest budget committee; board of the District Nurses Association; board of the Columbus Goodwill Industries, of which he was past-president; board of trustees of the Better Business Bureau of Columbus; and the board of directors of Ohio Medical Idemnity, Inc.

Mr. Mauck was born in Point Pleasant, W. Va., and was brought by his family to Ohio at the age of 3. He graduated from Gallipolis High School and received his B. A. degree from Ohio Wesleyan University, class of 1916. The next year he received an M. A. degree from Harvard University. During World War I, he served in the Infantry and attained the rank of captain.

Business affiliations before he entered medical organization work were with the Goodyear Tire and Rubber Company and the Firestone Tire and Rubber Company.

An active church member, he served in a number of offices at North Broadway Methodist Church and as a lay delegate to church conferences. He was a member of the Rotary Club, University Club, several Masonic bodies, the National Alumni Association of Ohio Wesleyan University and the Ohio Wesleyan board of trustees, Beta Theta Pi and Omicron Delta Kappa.

He was a member of the Columbus area Chamber of Commerce, member and past-president of the National Association of Medical-Dental-Hospital Bureaus of America, also former interim executive secretary and editor of the association's magazine, charter member of the National Association of Telephone Answering Services, and author of its constitution and bylaws, member of the National Society of Professional Business Consultants.

In 1920, Mr. Mauck married Helen McKay, who survives, with two sons, Robert S. Mauck, also affiliated with the Medical Bureau, and the Rev. Donald M. Mauck, D. D., associated with the Methodist Theological School of Ohio in Delaware; also six grandchildren.

State Medical Board of Ohio Issues Annual Report

The State Board of Ohio annual report for 1965, submitted to the Governor, shows the following information:

Four regular meetings, four called meetings, and two special meetings were held. Examinations were conducted in Columbus, June 17-19 and December 16-18.

By examination, 363 graduates in medicine were issued certificates to practice. Sixty-seven osteopathic applicants were successful and were issued certificates to practice osteopathic medicine and surgery. Seventy-one limited practitioners were awarded certificates to practice in the limited fields. Twenty-four chiropodists (podiatrists) were also issued certificates to practice in their branch. There were 15 physical therapists licensed by examination during the year.

By endorsement, the Board issued certificates to practice to 524 medical applicants who had qualified in other states. Eight applicants also qualified by endorsement for the practice of osteopathic medicine and surgery, and 50 physical therapists were issued certificates by endorsement.

The entrance examiner issued 1040 certificates of preliminary education to medical and osteopathic applicants and 130 certificates to limited practitioners.

Hearings for violation of the law were held in 41 cases of licensed practitioners. Hearings were postponed to a later date for four doctors of medicine, one osteopathic physician, and two limited practitioners.

Placed on probation and requested to report again were three doctors of medicine, one osteopathic physician and one limited practitioner. Three doctors of medicine were discharged from probation.

Under the legal requirement for yearly renewal of osteopathic licenses, 1353 renewals were issued, and 104 reinstatements made. Renewals of chiropodists' licenses number 615, with 56 reinstatements. Physical therapy renewals numbered 565.

Investigators for the Board made 2854 calls and investigated 317 cases in 60 counties during the year.

The Southwestern Ohio Society of Family Physicians, in collaboration with the University of Cincinnati, presented a seminar on "Forensic Medicine" on February 10.

The older patient needs a special laxative

The geriatric patient is notoriously prone to constipation—and to an atonic, 'tired' bowel □ Inadequate nutrition, chronic diseases, repeated use of cathartics, plus the aging process itself all interfere with the physiology of elimination.



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WARNING: Anesthetics have been found to increase the hypotensive effect of reserpine. Caution should be taken to withdraw patients from SERPATE® (reserpine) two weeks prior to administering anesthetics or to elective surgery. Use with caution in gravid patients. Reserpine passes the placental barrier and may affect the newborn.

M. D.'s in the News

Dr. John A. Prior, associate dean of the Ohio State University College of Medicine, spoke at the annual staff dinner meeting of the St. Luke's Hospital in Toledo, where he discussed the changing approach to medical school curricula and the problems facing modern medical education.

* * *

Dr. Jack Schreiber, Canfield, was guest speaker at a meeting of the Massillon American Education Council. He discussed the encroachment of increasing governmental programs into the American way of life.

* * *

Dr. Clyde W. Muter, was elected president of the Warren Board of Education.

* * *

Dr. Franklin C. Hugenberger spoke to the Columbus Downtown Sertoma Club's Ladies Day Meeting. He discussed his recent Caribbean voyage.

* * *

Dr. Lester G. Parker, Sandusky, was speaker for the Sandusky Area Industrial Management Club, on the topic "Prophylectic Health Measures and Related Problems."

* * *

Dr. C. Joseph Cross discussed the heart and heart disease at a meeting sponsored by the Junior and Senior Leagues of the First Lutheran Church in Columbus.

* * *

Dr. David W. Sprague discussed "Emotional Problems," especially those related to retirement, at a meeting of the Lakewood Women's Club.

* * *

"Causes and Types of Mental Retardation" was the topic discussed by Dr. Robert D. Mercer, Cleveland, at a meeting in Mansfield sponsored by the Richland County Association for Mentally Retarded.

* * *

Three physicians participated in a public forum on "Emotional Problems of Everyday Life," sponsored by the Jewish Community Center and Mt. Sinai Hospital in Cleveland. Speakers were Dr. Benjamin Berger, Dr. Ernest Friedman, and Dr. Alvin Sutker.

* * *

"The Heart of the Executive" was the theme of the Central Ohio Heart Association meeting in Columbus. Keynote speaker was Dr. Eugene Z. Hirsch, research physician in radioisotope service at the Veterans Administration Hospital in Cleveland.

* * *

As president of the East Central Ohio Heart Association, Dr. Igor Nikishin, Canton, delivered the kick-off address for the Tuscarawas County Heart Association fund-raising campaign.

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Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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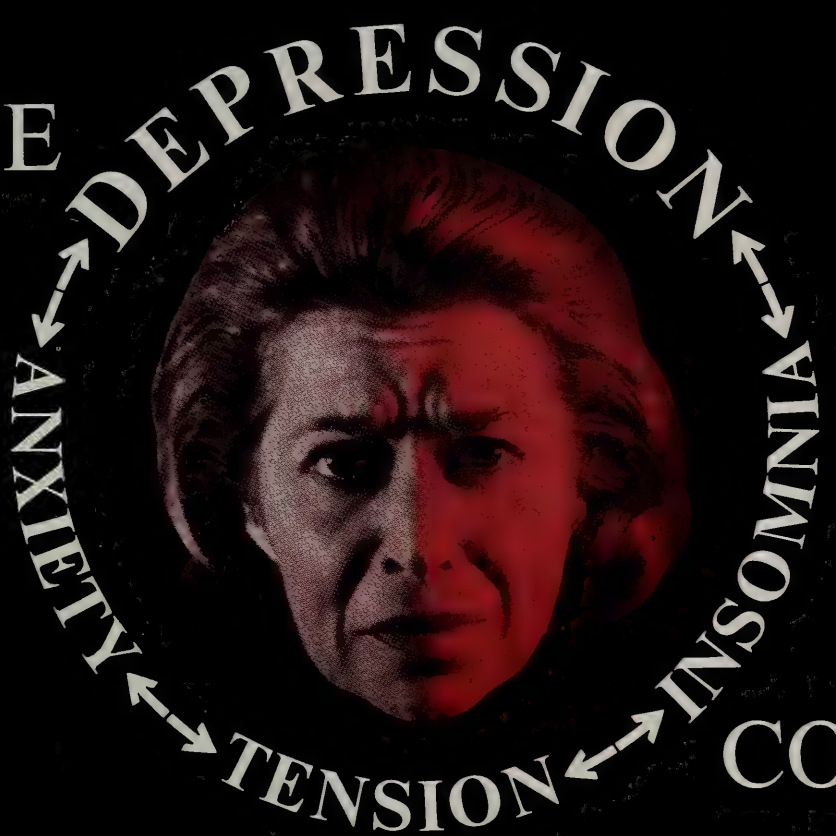
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Levi Rogers

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PART II

(Continued from February Issue)

LEVI ROGERS soon convinced himself that its central location made Franklin County the better site for Ohio's permanent seat of government and worked for that location. It turned into a touch-and-go legislative battle. The Chillicothe group was strong and very alert. Their bill came up the first time in the Tenth Session in the Senate on December 12, 1811. The vote was tied 11-11.

Early in February 1812, four able, far-sighted men from Franklin County came to Zanesville with a free offer of 100 acres of suitable land plus an offer to build a capitol, a government office building, and a prison if their offer were accepted for the permanent seat of government. The Senate accepted this offer February 14, 1812, by a vote of 17-7, first reading and appointed Joel Wright of Warren County as director. [When I read this far in the Senate Journal, I in my simple ignorance, thought the matter settled.] However, in the next few days, three times amendments were offered which would have substituted Chillicothe. When these failed to pass, the Chillicothe party strategy shifted. Their first suggestion was to postpone the bill for one year. This brought a tie vote, 12-12. The next was a request that U. S. Military lands be used, (lost 10-14); then that Chillicothe be made the temporary seat (lost 11-13); still another similar amendment the same day failed 9-16.

Levi Rogers, who had been closely following every move, sensed that the opinion of the Senate was beginning to crystalize against the blocking tactics from Ross County. He jumped to his feet and called for the third reading of the bill. It passed 17-5. The next day when the final question was asked, "Shall this bill pass?" it was carried 13-11. On February 19, 1812 the four proprietors signed their bond to build the capitol.

On February 21st, the last day of the session, Levi Rogers rose in the Senate and proposed that "the land opposite Franklinton selected for the permanent seat of government be named COLUMBUS." His motion passed without a roll call. Some history books tell us that the name Columbus was originally put forward by Gen. Joseph Foos of Franklinton.[3] Perhaps Senator Rogers was following his suggestion.

Medical Legislation

Bancroft in writing of Levi Rogers as a State Senator only mentions the first Ohio laws regulating the practice of medicine. He credits Rogers with writing and securing their passage and considers these laws a lasting monument to the good doctor. There is ample evidence that Rogers played an active part in drafting and passing the medical bills of 1812 and 1813.

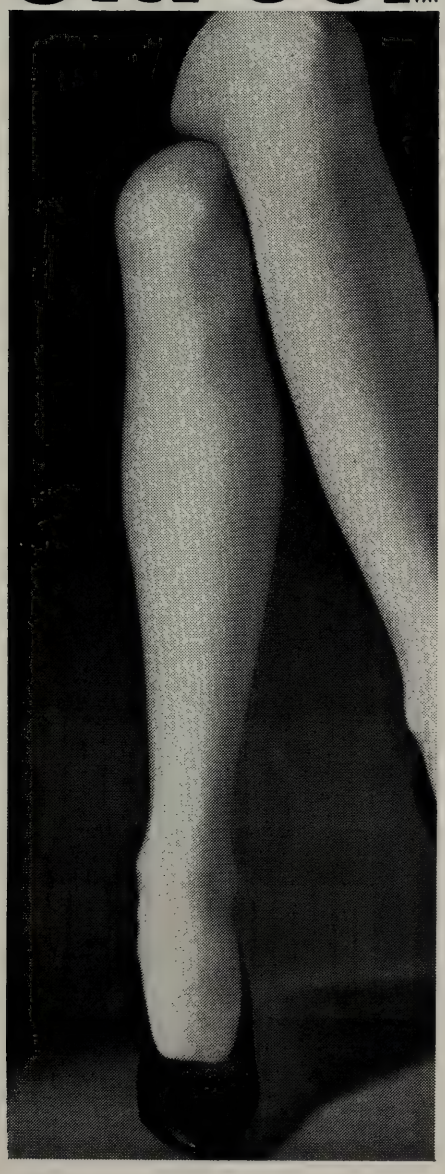
The first mention of a bill in Ohio *To Regulate the Practice of Medicine* occurs in the House Journal of the Eighth General Assembly stating that a medical bill is being held over to the Ninth Session. Early in the Ninth Assembly, Dr. Samuel P. Hildreth was appointed chairman of a House committee to pick up this medical bill, and eventually it did become the first law regulating the "Practice of Physic and Surgery" for Ohio. Effective January 14, 1811, the law set up five medical licensing districts, each one corresponding roughly with the five historical settlement areas, each with its own local board of doctors, each board setting its own standards. There seems to have been much dissatisfaction with this effort.

So, in the Tenth Assembly, the House set up a new committee to improve the bill. This committee ended up by bringing in a substitute bill entitled "An Act to Incorporate a Medical Society." This was in line with the precedent first set by Massachusetts, of delegating the responsibility of medical licensing to a state medical society. On receiving this bill from the House, the Senate appointed a committee of three of whom Levi Rogers was the second man named, to study it. He was well aware that Ohio at that time contained more quacks than doctors and he was eager to see the people protected. He considered that medical societies in the older

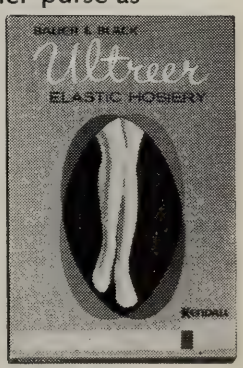
*Dr. Greene, New Richmond, is a member of the staff, Brown County Hospital at Georgetown; Yale in China, emeritus Professor of Surgery.
Submitted February 3, 1965.

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states were proving helpful but had some question how well a society could be set up by law instead of growing up through the efforts of the medical profession itself.

When this senate committee failed "to make progress," it was discharged and this medical bill redelegated to an entirely new committee. It was finally passed February 6, 1812, with Hildreth voting "nay" and Rogers "yea." But the War of 1812 blocked its implementation. Of the 21 delegates elected to organize the Medical Society only five showed up and, as the law specified the quorum at ten, no action was taken.

So the Eleventh General Assembly had to tackle medical legislation again. This time the Senate appointed a committee with Levi Rogers chairman. They promptly brought in a bill to "regulate the Practice of Physic and Surgery" which went through all the necessary procedures and became law January 19, 1813. It resembled the law of 1811 but had seven instead of five districts and each district had seven censors instead of three. It also added a fine of from $5 to $75 for every offense of practicing without a license. Any Justice of the Peace was empowered to handle such cases.

It would seem from these records that when historian Bancroft writes, "the medical Acts of 1811 and 1812, introduced and passed by him (Levi Rogers) of themselves are a permanent monument of his ability and zeal as a physician,"[4] that he was reflecting the local Clermont County tradition of about 1880, rather than history.

Levi Rogers took his senate responsibilities seriously. According to the Senate Journals for the Tenth and Eleventh sessions he did not miss a single roll call. He was chairman of 13 different committees and served as a member of 11 other committees. He was a witness against Judge John Thompson, President of the Court of Common Pleas, at his trial for impeachment as well as one of the Senators trying him.

Rogers voted for all bills furthering education and libraries, for curbing the abuses of liquor, for road improvements and for better state organization.

Army Surgeon, War of 1812

Sometime in March 1813 Dr. Rogers was called up for active duty as Surgeon of the 19th regiment, U. S. Infantry. He was assigned to the contingent under Col. John Miller which was sent to Ft. Meigs. Gen. William Henry Harrison was in charge of the efforts to prevent the British from invading from Detroit and was erecting this fort. By April this camp also included several companies of Ohio Militia. Later some Kentucky forces joined them. Dr. Rogers noted "much colds and some pneumonia."[5]

This camp stands on the east bank of the Maumee River. In late April word came that British General Proctor commanding regulars and Canadian Volunteers had left Detroit and that thousands of Indians under Tecumseh were joining him to wipe out Ft. Meigs. By April 27th the British reconnoitering party was on the west bank watching the Fort. Soon their full force arrived; 600 British regulars, veterans from the Napoleonic Wars, 800 Canadian Volunteers and some 1800 Indians — a total of 3,200 men. The American forces totaled 1,200 of whom some 200 were sick.

During the next two days British artillery was placed along the west bank and on May 1st the bombardment of Ft. Meigs began.

> We were not prepared for this. That night all hands fell to and raised a huge mound of earth running through the middle of the camp parallel to the river. Two days later a second shorter mound was raised at right angles to the first, protecting the men in the fort from batteries placed north of the camp on the east bank. These traverses were 17 feet high and sufficiently thick to withstand the enemy fire. In the one quarter of the camp behind these earthworks our men found complete shelter.[6]

May 3rd the Indians attempted to entice an American sally but Gen. Harrison did not budge. On May 4th General Proctor sent over a demand for the surrender of the Fort. Harrison sent back, "Take the Fort if you can. You will gain more honor than by a thousand surrenders."[7]

To destroy the buildup of British forces on the east bank, Harrison decided to make a surprise attack on the Indian concentration in the woods north of Ft. Meigs. He ordered Col. Miller to take the British batteries while this attack was in progress. The 19th Infantry formed the main body for this sortie. It was successfully executed the night of the 4th. There were 350 Americans against an estimated 850 British. The American losses were 28 killed and 125 wounded, — 44 per cent of their force.

The result of this victory exceeded expectation. Tecumseh, completely fed up with Proctor, made no move to hold his Indians, who "drifted away in droves." General Clay arrived from Kentucky with reinforcements, some of whom succeeded in getting into the Fort. By May 9th an epidemic of dysentery was raging through the British camp. Gen. Proctor decided to "await a better time" and withdrew.

And Levi Rogers was an active participant in all this. At the end of the fighting Gen. Harrison reported the American casualties as "81 killed and 189 wounded. None captured." On May 11th he left for Chillicothe taking with him all the 19th Infantry able to travel and leaving Surgeon Rogers to care for the sick and wounded.

(To Be Concluded in April Issue)

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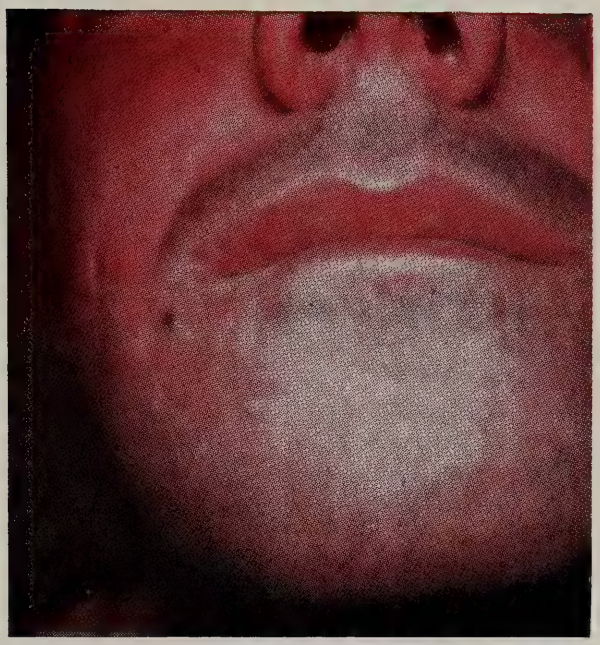
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Ohioan to Play Leading Role in ACP New York Meeting

Dr. A. Carlton Ernstene, Cleveland, will play a leading role as president when the American College of Physicians holds its 47th annual meeting in New York City, April 18-22.

Dr. Ernstene will address the college on Monday morning, April 18, and preside at business meetings of the organization. He will be honored at the president's reception and dinner dance on Thursday evening.

Advance programs, mailed to physicians, listed five days of scientific sessions at the Americana and New York Hilton hotels with presentations by more than 300 medical scientists. Among the highlights will be award lectures by international experts in the fields of liver disease, cardiology, cellular replacement, cholera and dietary protein deficiency.

The internists will also hear a report on the present status of kidney transplantation by Boston surgeon, Dr. John P. Merrill, and a presentation on drugs and the public safety by Dr. Joseph F. Sadusk, Jr., Washington, D. C., medical director of the Food and Drug Administration.

Information on late developments in the diagnosis and treatment of diseases will be offered to the specialists via plenary sessions, panel discussions, special lectures, closed-circuit television programs, basic-science and clinical-investigation presentations. Throughout the week, the physicians will visit selected medical facilities in Manhattan.

Additional information may be obtained from the college at 4200 Pine Street, Philadelphia, Pa. 19104.

Seminar on Premature Care Scheduled At Cincinnati Good Samaritan

The Good Samaritan Hospital, Cincinnati, Ohio, has announced the Fourth Annual Seminar on Premature Care to be held April 21, from 1:00 p. m. to 6:00 p. m. Guest speakers will include Dr. Mary Engle, associate professor of pediatrics, Cornell University Medical College; Dr. Alvin Zipursky, assistant professor of paediatrics (haematology), University of Manitoba, Faculty of Medicine; and Dr. William B. Richardson, Department of Surgery, Good Samaritan Hospital.

There are no registration fees but physicians planning to attend are requested to contact Ernst G. Rolfes, M. D., Chairman, Seminar on Premature Care, Good Samaritan Hospital, Cincinnati, Ohio 45220.

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"Death to Measles" Article Poses Lesson in Latin

In the January issue of *The Journal,* the Ohio State Medical Association announced the launching of an educational program to stress the importance of immunization against measles.

The initial article on this subject was introduced with a real eye-catcher — "Mortus a Morbilli." As authority for this slogan, *The Journal,* and all persons concerned with publication of the article, fell back to the American Academy of Pediatrics which used the phrase in its statement on current status of measles vaccine.

Even before the January issue was fully in circulation, *The Journal* began to feel reverberations from this liberty with the classical language. "Fractured Latin," wrote one *Journal* reader. Another doctor referred to the phrase as "mock Latin" and deplored the fact that such "trenchant remarks" should be introduced with "a line of gibberish." Still another reader, who chose to remain anonymous, recommended that persons responsible for the "deplorable errors" might "go back to high school."

The quotation intended to read "Death to Measles," according to a spokesman for the American Academy of Pediatrics.

And how does one translate "Death to Measles" into Latin? One scholar did not find the word for measles in his dictionary of the ancient language. (Webster gives a Medieval Latin derivation.) This same scholar would write the slogan as "mars morbillibus," since the preposition "a" is not needed and the word for measles takes the dative case.

Another scholar agrees that if the word for death was intended it should be in the form of "mors," but he would write the phrase "a morbillis" since "a" or "ab" is followed by the ablative.

All of which seems to indicate that literal translations into Latin may be awkward. In its predicament, *The Journal* appealed to the Department of Classical Languages at Ohio State University. A spokesman there agreed that the original phrase was an "ill-begotten" slogan and complimented those readers who caught the mistake. "I was delighted to peruse the various letters of protest written by physician-Latinists (Latinist-physicians?) occasioned by the faulty slogan," he wrote. "It is gratifying to know that the average physician's knowledge of the Classical Languages goes beyond the *hysterosalpingo-oophorectomy* level."

The OSU professor declined to give a literal translation of the phrase. His letter continued as follows:

"The Latin version which I should like to suggest is *Pereant Morbilli!* The phrase, literally translated, means 'May the measles perish!' Idiomatically (and I gather that you are primarily interested in good, idiomatic Latin), the phrase means exactly what you want: 'Death to Measles!' "

So be it! And — slogan or no slogan — for an excellent article on immunization against measles, including dosage schedules, refer to the January issue of *The Journal,* pages 18-19. *Pereant Morbilli!*—RGM.

Do You Know? . . .

Dr. Charles L. Hudson, Cleveland, President-Elect of the American Medical Association, opened a panel discussion on the subject, "Medicare, Panacea or Pitfall," sponsored by the Western Reserve University Adelbert Alumni Association. Robert A. Lang, executive secretary of the Academy of Medicine of Cleveland, also participated in the panel discussion.

* * *

Dr. Richard L. Meiling, Columbus, dean of the Ohio State University College of Medicine and director of University Health Center, was featured speaker for the 48th annual banquet of the medical staff at St. Rita's Hospital in Lima.

* * *

Dr. George J. Hamwi, professor of medicine at Ohio State University College of Medicine, was reelected president of the Central Ohio Diabetes Association at its recent annual meeting.

* * *

Two Ohio physicians were elected to the Board of Chancellors of the American College of Radiology at that group's annual meeting in Chicago. They are Dr. Benjamin Felson, of Cincinnati, and Dr. Paul A. Jones, Zanesville.

* * *

Dr. James V. Warren, professor and chairman of medicine in the Ohio State University College of Medicine, gave the principal address at the Georgia Heart Association's annual meeting in Atlanta. He also was presented a plaque by the association in commemoration of the first use of heart catheterization to diagnose congenital heart disease. Dr. Warren reported this technique in 1944. His collaborators were Dr. H. Stephen Weens, chairman of radiology at Emory University, and Dr. Emmett Brannon, who is now in practice in Rome, Ga.

* * *

Dr. and Mrs. Max Roy Hickman, Columbus, have been commissioned missionaries and will join the staff of the Methodist Hospital at the Nyadiri Mission Center in Rhodesia. Dr. Hickman has been a resident in surgery at Riverside Methodist Hospital. Mrs. Hickman will work in the field of medical technology.

* * *

Dr. William W. Davis, resident of Westerville, and medical director of North American Aviation in Columbus, has been promoted to the rank of Brigadier General in the U. S. Army Reserve. His military assignment is as Commanding General of the 3391st U. S. Army Hospital.



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OSMJ Scientific Section

VOL. 62 MARCH, 1966 NO. 3

Carcinomatous Neuromyopathies

A Review of Neurological Syndromes Associated with Malignant Neoplasms and Unrelated to Metastases

TIMOTHY FLEMING, M.D.

FOR YEARS it has been known that disorders of the nervous system and the musculature can occur in association with malignant tumors of the viscera, unrelated to the presence of metastases. In 1888 Oppenheim[21] reported a case of peripheral neuritis associated with a malignant tumor and suggested that a toxic process could be incriminated. Numerous articles appeared on the subject in the early twentieth century.

In 1948 Denny-Brown[6] described in detail the clinical and histological picture of two cases of sensory neuropathy in patients with carcinoma of the lung. He felt that the histologic picture resembled changes associated with pantothenic acid and vitamin E deficiency in animals. Selective degeneration of the granular layer of the cerebellum was demonstrated in patients with visceral carcinoma by Leigh and Meyer in 1949.[19] In 1950 Lennox and Prichard[20] drew attention to peripheral neuropathy occurring in patients with lung cancer. In 1951 Brain, Daniel, and Greenfield[2] reported four cases of subacute cerebellar degeneration associated with carcinoma. In 1958 Brain and Henson[3] described 42 cases of carcinomatous neuromyopathies. In 1961 Diamond[7] reviewed the literature concerning carcinomatous neuropathy.

The location and the structural involvement of visceral tumors associated with changes in the nervous system have been found to be fairly constant. Tumors of the lung have long been known to be associated with deleterious effects on the nervous system. Lennox and Prichard[20] reviewed 299 records of patients with bronchial carcinoma admitted to the Hammersmith Hospital, London, during the eight years from 1939 to 1948, and found five cases with peripheral neuritis. They also noted that of 11 patients with whom they were familiar, the left lung alone was involved. In a group of 1309 patients with bronchial carcinoma studied at the Bernhard Baron Institute of Pathology, London, between 1940-1952, fifteen had neuropathies (1.1 per cent). However, there were 276 necropsies on patients with lung carcinoma during the 17 years 1936-1952 and these included six with neuropathy (2.2 per cent). Five of these six necropsies were done in 1950 and 1951.[16] This appears to represent a considerable and alarming increase in frequency of such lesions. Heathfield and Williams[15] reported four cases of peripheral neuropathy and myopathy in the presence of bronchogenic carcinoma. Charatan and Brierley[4] described three patients with bronchogenic carcinoma all of whom

The Author

● **Dr. Fleming, Cincinnati, presently is an Intern at Cincinnati General Hospital.**

A thesis submitted to the Department of Neurology, University of Cincinnati College of Medicine, during the author's Junior year of medical school — 1964.

Submitted for publication July 9, 1965.

demonstrated profound mental changes without associated neurological signs. In Brain's series of 42 patients with carcinomatous neuromyopathies, 32 had lesions in the lung (males 23, females 9), and 17 of the 19 patients studied by Henson, Russell and Wilkinson also had lesions in the lung.[3,16] It is of interest that when the clinical picture has been one of sensory neuropathy or polyneuritis, the accompanying carcinoma, with but few exceptions,[8,23] has been found in the lung.

A much higher incidence was reported by Croft and Wilkinson.[5] These investigators studied 250 men with carcinoma of the lung and 250 women with carcinoma of the breast. The incidence of neuropathy was found to be 16 per cent and 4.4 per cent, respectively. This study would indicate that carcinomatous neuropathy is much more frequent than formerly believed.

A small number of patients have manifested neurological syndromes in association with carcinoma in regions other than the lung. Thus in Brain's series of 42 cases of neuropathy associated with carcinoma, four were found with tumors of the ovary, two were associated with tumors in the prostate, two involved the rectum (both males), and two manifested tumors of the breast.[3] In Henson's study of 19 cases of neuropathy associated with carcinoma, one was associated with a tumor of the ovary and another was associated with a tumor of the breast.[16] Both of these latter cases manifested subacute cerebellar degeneration. More recently Swan and Wharton[23] reported one case of polyneuritis in which there was strong evidence to suggest that a "clear-celled" carcinoma of the kidney was the primary tumor.

The importance of the locations commonly found to be harboring malignant tumors in association with various neurological syndromes cannot be overemphasized. It can readily be seen that the possibility of demonstrating a malignant tumor to which effective therapy can be directed may be greatly enhanced by familiarity with the specific neurological syndromes frequently seen with such lesions and familiarity with the areas from which they most commonly arise. With this goal in mind, it would be of value to review these neurological syndromes both from the pathological as well as from the clinical viewpoint.

Clinical and Pathological Features

Brain and Henson[3] found that their series of 42 patients who manifested neurological syndromes in association with malignant tumors divided themselves into five fairly distinct clinical categories. Eight of their patients manifested primarily cortical cerebellar degeneration, seven patients demonstrated mixed neurological forms, sensory neuropathy was predominant in five patients, peripheral neuropathy (sensorimotor) was the most frequent syndrome in five patients, and neuromuscular disorders were predominant in 17 patients. Although the carcinomatous neuromyopathies are rarely manifested as pure clinical forms, this grouping will be utilized as a classification to facilitate the discussion of the clinical and pathological features which are frequently found.

Cortical Cerebellar Degeneration

As early as 1949, Leigh and Meyer[19] found a curious degeneration of the granular layer of the cerebellum in eight patients with visceral carcinoma. In six of their cases there was a marked reduction in nerve cells in the inferior olive. Two of the eight cases, however, manifested secondary deposits in the cerebrum. One patient's illness was complicated by Wernicke's syndrome, another by Korsakoff's psychosis, and a third by oral signs of vitamin B deficiency.

Brain and Henson[3] found a striking loss of Purkinje cells in the cerebellar cortex, one patient having no demonstrable cells of this type remaining. In addition to the loss of Purkinje cells there was slight rarefaction of granule cells, but a remarkable preservation of the basket cells. Early degeneration of the direct cerebellar tracts and dorsal columns as well as lymphocytic cuffing in the cerebellum, medulla, and spinal cord were also seen. Henson, Russell, and Wilkinson[16] noted that the carcinomata associated with cerebellar disorders in their series were predominantly in the ovary, lung, breast and uterus — those in the ovary and lung being the most frequent (three in the lung, one in the ovary, one in the breast). Only one case showed significant degeneration of the cerebellar cortex. Two cases exhibited histologic findings referred to as "subacute cerebellar degeneration." These patients manifested degeneration and loss of motor neurons in the spinal cord and medulla resulting in a picture of a chronic progressive poliomyelitis. A cerebellar element was also seen, however, with degeneration and loss of cells of the dentate nucleus, loss of fibers in the cerebellar peduncles, and degeneration of cells in the cerebellar cortex in one case.

From the clinical viewpoint, all five of these patients had a mixed neurological picture. Euphoria and dementia occurred in three of the five patients, and mental anguish necessitated prefrontal leukotomy in another. The mixed neurological picture will be discussed in detail presently. As reported by Brain and Henson[3] in eight of their patients, the clinical picture found in cortical cerebellar degeneration was seen to be severe cerebellar deficit in the limbs, dysarthria, diplopia, and nystagmus. Mental changes were predominant in this group and all but one of their patients were eventually demented. Extensor plantar signs were present in some patients and one had continuous involuntatry movements. It was noted that the deterioration may be quite rapid and progress to inability to walk or stand within two weeks, or that

it may take several years to progress to a full clinical picture.

Mixed Neurological Form

This form of myelopathy associated with carcinoma has been generally referred to as "subacute spinocerebellar degeneration," although Henson, Russell and Wilkinson have pointed out the inadequacy of this term.[16] The neoplasm associated with this neurological syndrome has been found most commonly in the lung or breast.[13, 3] In general its course has been seen to be more chronic than that of the other neuropathies. In 1934 Greenfield[13] described two cases of subacute spinocerebellar degeneration in which histologic examination revealed degeneration of the long tracts of the cord, especially the dorsal columns and cerebellar tracts, with earlier degeneration of the pyramidal tracts. There was gross loss of Purkinje cells in the cerebellar cortex. The superior cerebellar peduncles and the longer tracts of the tegmentum of the brain stem were involved in one case. The nucelus of Luys and the strio-Luysial fibers were degenerated in both cases. There was fairly intense perivascular infiltration in the region of the degenerated tracts. Greenfield found a pleocytosis and an excess of protein in the cerebrospinal fluid in both of these cases.

Similar histologic changes were described by Brain and Henson[3] in seven of their cases manifesting clinically a mixed neuropathy. These investigators found degeneration of the cells of the dentate nucleus associated with loss of fibers in the superior cerebellar peduncles. Degeneration of the motor cells in the spinal cord and brain stem nuclei associated with degeneration of the pyramidal tracts and posterior columns in the spinal cord were similar to the changes described by Greenfield. Cellular infiltration of the meninges and perivascular cuffing of the vessels of the spinal cord and the medulla below the floor of the fourth ventricle were also prominent findings.

As one might imagine from the histologic picture, the clinical features included muscular wasting and weakness in many areas of the body. Frequently there was an extensor plantar response, but the tendon reflexes were generally reduced. Involuntary movements were occasionally prominent, pains and dysesthesiae in the limbs were often severe, and impairment of postural, vibratory, and occasionally cutaneous sensation also occurred. Again mental changes were frequently prominent. The course of the illness was usually long, extending over two years, but it was noticed that the symptoms were such that the patient usually sought medical advice within a few weeks of onset.

Greenfield's cases[13] also manifested pains in the limbs and weakness and ataxia of the legs and arms, dysarthria, and mental enfeeblement. It is of interest that a small breast tumor had been removed nine months before the onset of these signs and symptoms in one patient, and the other patient demonstrated a bronchogenic carcinoma at autopsy. Greenfield did not, however, mention that a connection might be made between the tumors and the neurological findings.

Peripheral Neuropathies

One of the most widely recognized neurological manifestations associated with visceral carcinoma has been that of peripheral neuropathy, either purely sensory or mixed sensorimotor. In general, the sensory type has been associated most commonly with bronchogenic carcinoma, although Dodgson and Hoffman[8] reported one case associated with carcinoma of the esophagus. In 1948 Denny-Brown[6] eloquently described the clinical and histological findings in two patients with sensory neuropathy associated with bronchogenic carcinoma:

> The most remarkable change in the two patients presented was the severe loss of nerve cells in the dorsal root ganglia, without corresponding change in the ventral roots.
>
> . . . In the two cases presented here a number of intermediate changes in the process of disintegration of the ganglion cells was seen.
>
> . . . The whole process of ganglionic degeneration presented the appearance of a primary atrophic process of the nerve cells, without inflammatory or vascular reaction. . . . In both instances the lumbo-sacral ganglia were the most heavily affected, but the disorder was widespread.
>
> . . . In contrast to the ganglionic changes in tabes the degeneration of the peripheral process of the ganglion cell was as severe as of the central.
>
> . . . The muscles also presented an unusual type of change. Proliferation of sarcolemmal nuclei and increased cellularity of the connective tissue of a kind seen in chronic myositis, or rapidly progressive myopathy were found in both cases.
>
> . . . The condition therefore, points to a diffuse degenerative process affecting primarily dorsal root ganglion cells, associated with a degeneration of striped, voluntary, muscle fibre.

Essentially the same histologic features were found in five similar cases of sensory neuropathy described by Brain and Henson.[3] In addition, however, they found an intense lymphocytic infiltration of the posterior root ganglia in association with degeneration of the peripheral nerves and gross perivascular cuffing in the medulla in the floor of the fourth ventricle. Dodgson and Hoffman[8] found similar histologic changes in a patient manifesting sensory neuropathy with an associated carcinoma of the esophagus. Heathfield and Williams[15] noted symmetrical and extensive degeneration of the posterior columns of the cord and posterior nerve roots. Gliosis of the posterior columns was severe. There was also various degrees of degeneration of the posterior root ganglion cells.

The clinical features seen in the sensory neuropathies are frequently quite striking, and a description of some specific cases may be warranted. Denny-Brown[6] described two such cases, one of which began as an ache in his right ear radiating into the right side of the neck. About two weeks later he devel-

oped numbness of the soles of both feet which advanced up the legs over a period of about three days. At that time he developed numbness around his mouth which gradually spread to involve his whole face within several days. At the same time his hands became numb. About one month later he began to have intermittent tingling sensations in both hands and both feet. During this period he had intermittent stabs of pain in the medial aspect of the ankles which radiated to the knees and buttocks, while the numbness spread up the legs to the knees and up the forearms to the elbows. On physical examination hearing was found to be severely diminished, and there was absence of pain over the entire face and tongue. Light touch was also reduced in these areas leaving only impaired deep sensibility and temperature sense remaining. Ataxia was prominent and he was unable to sit up or walk without assistance. All muscles of the lower extremities were atrophied to a greater extent than could be accounted for by general cachexia. Deep reflexes were diminished or absent, but the plantar responses were flexor. Pain, light touch, and temperature were impaired over the whole body.

Henson, Russell and Wilkinson[16] reported three such cases, all of them occurring in association with carcinoma of the lung. Pathologically and clinically these cases were similar to those reported by Denny-Brown except in this series there was selective wasting of the intrinsic muscles of the hands in one case and extensor plantar responses in another.

Five of the 42 patients in Brain and Henson's series[3] had sensory disturbances. These authors pointed out that although a pure sensory neuropathy without motor weakness may be seen early in the course, a sensorimotor disturbance usually followed if the patient's course was prolonged. They also found associated symptoms of gross hysteria in two patients, dementia in one, and extensor plantar signs in another. The course varied from two months to more than a year.

That the ataxia seen in these patients is primarily due to a general deafferentation has been brought out in the cases described by Heathfield and Williams.[15] These investigators also stress that "there is often a greater loss of joint position and vibration sense than of cutaneous sensibility, and although a glove and stocking type of anesthesia is usual, on careful testing evidence of a radicular pattern may be found. . . ." Root pains of a shooting and burning nature were also present in two of their patients, one of which was mistaken for lightning pains of tabes dorsalis. One patient had "burning feet" which failed to respond to massive doses of parenteral calcium pantothenate.

Lennox and Prichard[20] were impressed by the complete lack of correlation between the size or rate of growth of the tumor and the progress of the sensory neuropathy. They noted that the neuritis may recede while the patient is dying of the neoplasm, while on the other hand, it may recur shortly after a pneumonectomy.

Peripheral neuropathy of the mixed sensorimotor type is one of the more common neurological complications of visceral carcinomata. Not infrequently the peripheral neuropathy will be purely sensory early in its course, yet weakness is often added to the clinical picture as the disorder lingers on. Five of the 42 cases studied by Brain and Henson[3] demonstrated a mixed picture, but again the clinical picture was not a pure one, and dementia and extensor plantar responses were occasionally present. Lennox and Prichard[20] studied the histologic picture in one such case and found the nervous lesion to be a demyelinization of peripheral nerves, chiefly motor, but in another case no lesion could be found in the brain, cord, or peripheral nerves.

A case of polyneuritis in which a clear-celled carcinoma of the kidney and a perinephric abscess were discovered at laparotomy has been described by Swan and Wharton.[23] The patient complained of pain and paresthesiae in the legs and was found to have loss of motor power and absence of all deep reflexes in the extremities. Facial weakness, as well as glove and stocking anesthesia and impaired proprioception, were also found. Before operation the neurological signs had remained unchanged despite treatment with injections of vitamin B complex, ascorbic acid, and corticotropin. One month after a left nephrectomy was performed his facial weakness had improved considerably, peripheral sensation had returned to normal, and there was only residual weakness in the right leg. The patient gained weight and progressively improved until the only physical signs were bilaterally absent ankle jerks.

Polymyositis and Neuromuscular Disorders

Carcinomatous myopathies can be divided into a purely muscular disorder (polymyositis) and a neuromuscular disorder (myasthenia-like syndrome). Howard and Thomas[17] have discussed myositis or polymyositis and feel that the same significant association with malignant conditions exists as occurs with dermatomyositis. About 7 per cent of patients with myositis or polymyositis have malignant lesions. These are usually found in older people and frequently involve the breast, rectum or colon, cervix, ovary, and lung. The clinical picture is usually an insidious onset of muscular weakness especially of the pelvic girdle, although acute fulminating cases have been seen.

In 1953 the neuromuscular disorder was first described by Anderson.[1] A patient with a myasthenia-like syndrome was found to have a bronchogenic carcinoma and a period of prolonged apnea followed the administration of succinylcholine in combination with anesthesia in preparation for surgery. Removal of the tumor resulted in a dramatic symptomatic im-

provement. Rooke, Eaton, Lambert and Hodgson[22] studied 19 such patients at the Mayo Clinic in whom the malignant tumor was most frequently located in the lungs or mediastinum. Of importance is the fact that several patients in whom the roentgenographic appearance of the chest was normal when the initial diagnosis was made, subsequently developed pulmonary neoplasms. There has been no consistent histologic abnormalities seen in the muscles in this disorder. In five patients studied by the same investigators,[22] the muscle was normal in appearance save for mild, scattered, nonspecific degeneration of muscle fibers, with occasional focal collections of sarcolemmal nuclei. In only one case did the abnormalities have the characteristics of myositis. This neuromuscular syndrome is distinct from myasthenia gravis but has many similar characteristics. It is of interest that 85 per cent of the involved intrathoracic carcinomata studied at the Mayo Clinic were of the small cell type.

Henson, Russell, and Wilkinson[16] found muscular wasting and weakness in 15 of their 19 patients with malignant disease which was over and above any wasting due to malignant cachexia. They concluded that lesions probably occur at more than one level in the neuromuscular apparatus and sometimes there is a disorder of the neuromuscular junction. These investigators emphasized that in some patients the basic pattern of the clinical picture was usually constant enough to make their recognition a relatively simple matter.

The clinical features of the myasthenia-like syndrome have been outlined by Greenberg, Divertie, and Woolner,[12] as follows: (1) proximal muscle weakness, particularly the pelvic girdle; (2) temporary increase in muscle strength after a few seconds of voluntary exercise; (3) absent or decreased tendon reflexes; (4) sensitivity to curare but poor response to neostigmine or edrophonium; and (5) associated peripheral paresthesiae. Brain and Henson,[3] found a similar clinical picture in 27 patients in their series.

Eaton and Lambert[9] have pointed out that the neuromuscular syndrome associated with malignant neoplasms may be differentiated from myasthenia gravis by electromyography and stimulation of nerves. In the neuromuscular syndrome associated with carcinoma the action potential of the motor unit is reduced in the resting muscle after a single supramaximal stimulus of the nerve but increases to a marked degree after a few seconds of exercise or tetanic stimulation. In myasthenia gravis, on the other hand, the action potential of resting muscle is normal and decreases with exercise.

Mental Changes

Mental changes have been a frequent accompaniment of malignant neoplasms. Charatan and Brierley[4] published an account of three cases of carcinoma of the bronchus associated with psychiatric symptoms which were described as nonspecific and resembling a fluctuating toxic confusional psychosis in which "lucid intervals" were obvious. These clinicians also had an opportunity to study their cases histologically. They noted that there was no degeneration of the cerebellar Purkinje cells, and no abnormalities in the spinal cord, dorsal root ganglia, or nerve roots were found. The white matter presented a honeycomb appearance caused by dilated perivascular spaces, which was felt to represent inter-fiber fluid of the central white matter of such brief duration that myelin damage and its associated glial reactions had not yet occurred. A mild to moderate marginal, subependymal, and white matter gliosis occurred in two cases, which suggested typical involutional changes occurring at a presenile age. In two of their cases the psychotic symptoms preceded symptoms due to the neoplastic growth. In all cases cerebral metastases or meningeal infiltration were absent, but liver metastases occurred in all three. Peripheral neuropathy and myopathy were not clinically demonstrable, nor was involvement of the cerebellum.

These authors suggested the possibility that some connection might be made between the liver metastases, which occurred in all patients, and the mental changes. Seventeen of the patients in the series reported by Brain and Henson[3] had mental changes. In none of these patients studied at autopsy were metastases found. The most common mental change seen was simple dementia (14 patients), but agitation and depression occurred in some. These authors noted that the dementia may become arrested with only moderate deterioration but there was no tendency toward remission. Dementia was most commonly associated with cerebellar symptoms.

Onset of Neurological Symptoms and the Appearance of the Malignant Tumor

A malignant neoplasm may be suspected from characteristic neurological findings and investigations instituted to identify the malignant lesion while it may still be amenable to therapy. Brain and Henson[3] point out that although the neuromyopathy may develop pari passu with the tumor, neurological symptoms may antedate the clinical manifestations or diagnosis of the growth by periods of at least three years. One such case had an eight year survival, at the time of the writing, after the surgical removal of a carcinoma of the lung. Occasionally, however, the neurological picture did not develop until the terminal stages of the carcinoma. The premonitory signs and symptoms of an early malignant lesion are frequently fleeting and elusive, however. In general, the surgical removal of the cancer has no effect on the course of the neurological syndrome. On the other hand, Henson, Russell, and Wilkinson[16] have been impressed with the tendency to spontaneous remission in carcinomatous neuropathies, as well as the

apparent lack of constant relation between the course of the neurological disorder and the carcinoma.

Investigations

Information gleaned from laboratory investigations in the carcinomatous neuromyopathies is usually disappointing. Brain and Henson[3] found abnormalities in the cerebrospinal fluid in five of eight patients with cortical cerebellar degeneration and in four of seven patients with the encephalomyelitic type. The changes included pleocytosis (up to 48 cells per cubic millimeter), increased protein (up to 120 milligrams per 100 cubic centimeters), and first zone Lange curve. No organisms were cultured, and the Wassermann reaction was always negative in the blood and the cerebrospinal fluid. A raised protein content, rarely with cellular increase, was common in sensory and sensorimotor peripheral neuropathies. The cerebrospinal fluid frequently returned to normal in a few weeks from the first examination.[16] In Charatan and Brierley's three cases[4] of mental change associated with carcinoma of the bronchus no abnormalities were noted in the blood or the cerebrospinal fluid.

Differential Diagnosis

Since considerable time may pass from the onset of the manifestations of the carcinomatous neuropathy until an underlying carcinoma is found, the etiology may be mistaken. Cerebellar forms must be differentiated from disseminated sclerosis, which they may simulate closely, as well as other forms of cerebellar degeneration.[16] Carcinomatous forms of subacute cerebellar degeneration are said to be the most frequent type seen in a general hospital.[3] A pure sensory neuropathy remains a rare manifestation of carcinomatous neuropathy and also of diabetes mellitus. The neuromuscular disorders are the most difficult to differentiate. The differential diagnoses of these disorders must include myasthenia gravis, motor neurone disease, dermatomyositis, myopathy of late onset and chronic thyrotoxic myopathy.[3,16]

Pathogenesis

One of the most intriguing aspects of the carcinomatous neuromyopathies lies in speculation on their causation. Many of the theories suggested in the past have been little more than speculation and significant data are limited. The lack of involvement of the nervous system by primary or metastatic spread of tumor raises many questions as to the pathogenesis of the neurological syndromes. Brain and Henson[3] have brought out certain factors which must be considered: (1) Only a small proportion of patients suffering from carcinoma develop neuromyopathy. (2) There is no relationship between the size of the growth and liability to neuropathy. (3) The incidence of neuropathy is much higher in lung carcinoma than in carcinoma elsewhere.

These authors have discussed five etiologic factors that may be invoved: (1) Toxins may be produced by the tumor, which in turn damage the nervous system. However, in such cases there should be some correlation of the size of the tumor and the severity of the neurological syndrome, which does not seem to occur. (2) The possibility of viral infection has also been considered, since some tumors are thought to harbor certain viruses. (3) A constitutional problem in resistance in some people known as "sensitization" may exist. (4) Since there has been a relatively high incidence of myxedema found in these patients, endocrine factors may be involved. (5) Metabolic factors, which at present are receiving the most attention, may be responsible for the neurological syndromes associated with carcinoma.

The latter mechanism has been discussed by Denny-Brown[6] who has noticed that the only disorder comparable to that seen in his cases, in which simple ganglionic degeneration is seen, is the ataxia of swine studied by Wintrobe and co-workers.[24] This type of picture was produced when swine were made deficient in pantothenic acid. Denny-Brown[6] has suggested that the bronchogenic carcinoma acts either by capturing some essential metabolite or by producing a substance of antivitamin type. However, since reversal of such degeneration as a result of feeding pantothenic acid, or pyridoxine, or vitamin E has not occurred, other factors are probably involved.

Lennox and Prichard[20] have challenged Denny-Brown's theory because of several apparent incongruities. The lack of relationship between the size or rate of growth of the tumor and the progress of the neuritis seem to cast doubt on the possibility that the mechanism could be the capture or production of a metabolite by the tumor. Also, since the bronchial carcinomata are varied in histologic type, including oat cell, squamous cell, and adenocarcinoma, it is difficult to explain why neuritis occurs more frequently in carcinoma of the bronchus, for if a metabolic effect is peculiar to neoplasms of the bronchial mucosa, it would seem odd that histologically they may be of diverse types. Finally, Denny-Brown looked to the damage in the posterior root ganglia to incriminate pantothenic acid; however, other studies have shown different lesions, including a pure demyelinizing peripheral neuropathy, predominantly motor.

Henson and associates[16] feel that the neuropathy and the carcinoma are linked by a common cause and do not feel that the condition is carcinotoxic. These workers found an abnormality in the pyruvate tolerance test in one patient as did Kremer and Pratt[18] and Heathfield[14] in similar cases. The latter author reported a case of peripheral neuritis, predominantly motor, associated with bronchial carcinoma. This case appeared to be of nutritional origin conditioned by histamine-fast achlorhydria; there was an associated nicotinic acid deficiency glossitis. The peripheral neuritis improved with administration of thiamine and the pyruvate tolerance returned almost

to normal. These cases would lend support to the theory suggested by Denny-Brown that the condition may be nutritional in origin. Other investigators have reported nutritional deficiencies in patients they have studied.[19]

The possibility that a deficiency of vitamin E may be involved must also be considered. Einarson[10] studied the effects of vitamin E deficiency in rats by examining fluorescent, acid-fast tissues. He found fluorescent, acid-fast deposits in the neurones of the central nervous system and elsewhere in vitamin-deficient rats. Einarson found greater amounts of this substance in five of the patients studied by Henson and associates than in the controls.[16] Histologic examination of the nervous system and muscles of vitamin E deficient rats by Einarson[10] demonstrated findings which are in many ways similar to those found in patients with carcinomatous neuromyopathies.

Heathfield and Williams,[15] however, stressed that their cases did not demonstrate lesions which appeared as acute as the lesions seen in experimental vitamin E deficiency. They described one patient with a pulmonary neoplasm who showed myotonia and responded well to quinine. One of their patients also responded to neostigmine. These investigators found inconsistent results in blood pyruvate estimations. Large parenteral doses of B-vitamins were of no value. Dimercaprol was also of no value. These authors concluded that there must be a multiplicity of factors involved in the pathogenesis of such lesions.

Brain, Daniel, and Greenfield[2] have stressed the special vulnerability of the Purkinje cells both in human disease and in experimental studies. The toxins of typhus fever, various poisons including lead, and ischemia of only brief duration are all known to cause detrimental effects to the Purkinje cell. But toxic factors had been previously challenged by Wyburn-Mason[25] who reported three cases of bronchial carcinoma presenting as polyneuritis. He suggested that the dysfunction of the nervous system was produced reflexly from the lungs:

> From the lungs afferent nerve-fibres enter the upper dorsal and vagus nerve-roots. Lung disease is not infrequently accompanied by the changes of hypertrophic pulmonary osteoarthropathy, the manifestations of which may be dramatically relieved by removal of the lung . . . In two cases known to me mere ligature of the pulmonary artery without removal of the lung had the same immediate effect. This shows that the changes in the tissues are not due to "toxic" aborption or anoxia, which would be increased by this procedure. They are probably reflex in causation. The polyneuritic syndrome might be of a similar nature.

There has been no subsequent work to verify this theory, and little credence is given to it.

An oat-cell carcinoma of the bronchus has been reported in which the tumor appeared to be producing 5-hydroxytryptophan.[11] What role such substances play in the genesis of neuromyopathies has yet to be determined.

It can be seen, then, that although the pathogenesis of the neurologic syndromes associated with visceral carcinoma have been explored from many aspects, the question is far from solved and a great deal of investigation is still necessary.

Treatment

The treatment is directed toward the associated cancer, adequate eradication of which may alleviate or diminish the neurologic symptoms. Physiotherapy is helpful in patients with neuromuscular disorders, and neostigmine may be of value in myasthenic cases. Cortisone should be of value in dermatomyositis.[3] It is doubted that vitamin therapy is of any value, but it is generally agreed that in our present state of knowledge adequate doses of vitamins, especially B and E, should be provided.[16]

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Supportive Psychotherapy*

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IN THE PRACTICE of medicine there is the ever present need on the part of people for supportive help in times of medical and other life crises. Corollary to this ever present need, there is also the opportunity for physicians in their daily practice on innumerable occasions and in innumerable ways to use supportive therapy for the benefit and welfare of their patients. It is my feeling that even though supportive psychotherapy is used by all physicians, its use is not generally well understood nor its importance fully appreciated. Because of the contributions of dynamic psychiatry, supportive therapy no longer needs to be or should be used haphazardly or willy-nilly, but rather it can be used intelligently and scientifically, the same as any other treatment measure.

Definition

Psychotherapy can be defined as a treatment measure which is administered through psychological techniques, which follows scientific principles, and which is designed to accomplish definite goals. While psychotherapy is a treatment measure for those patients suffering primarily from psychological and emotional disorders, it is an important and often a helpful adjunct to general medical and surgical therapies, because even in physical illness the patient's emotional and psychological life is often involved and should receive appropriate therapeutic attention.

Types of Psychotherapy

Psychotherapy can be divided into three main types: (1) supportive psychotherapy; (2) relationship therapy; and (3) psychoanalytic therapy, which is also known as uncovering or interpretative therapy. For this discussion I am not including such pluralistic and social approaches as group therapy and group activities of a social, recreational, and occupational therapeutic nature.

The type of psychotherapy to be used in a given patient is determined by three things: (1) the patient's emotional needs; (2) the treatment that the patient is capable of using and responding to; and (3) the capacity, training, skill, and competence of the physician. For each treatment there should be definite indications, goals, and techniques.

Supportive *versus* Other Psychotherapies

Psychoanalysis: Psychoanalytic psychotherapy is currently the most popular and prestigious form of psychotherapy. However, in considering the broad spectrum of psychiatric and emotional disorders, it has a somewhat limited use. It is a type of psychotherapy that requires a heavy investment of time, both for the therapist and the patient. Also in most instances it is an expensive form of treatment, which many people cannot afford. The psychoanalyst's training and preparation are long and expensive, which in itself limits the number of available therapists. Furthermore, the candidate for psychoanalytic therapy has to have certain qualifications making him suitable for such a technique. Besides having to have the resources of time and money, the patient must also have certain psychological assets and strengths. He must have normal or above normal intelligence. He must have a capacity to develop insight, which requires the ability to reflect and to correlate interpretation with personal experiences. Many patients who are emotionally sick and in real need of help do not have the psychological sophistication, insight, or motivation to utilize the psychoanalytic approach but they can be helped by other approaches.

Relationship Therapy: Relationship therapy is now a widely used therapeutic technique in the field of psychiatry. It utilizes the conception of dynamic psychiatry but in practice represents a compromise between psychoanalysis and supportive psychotherapy. Rather than emphasizing free association, introspection, interpretation, and insight, which are major tools of psychoanalysis, it emphasizes a relationship which embodies educated and insightful responses on the therapist's part to the patient's overt and hidden behavior. The emphasis is not on what the therapist says or interprets but upon his attitudes and upon what he does. Its goal is to provide a corrective emotional experience through the provision of a continuing constructive attitude and reaction on the therapist's part. From such a relationship, the patient can learn it is safe and possible to behave

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and to respond differently than his earlier life experiences had led him to believe.

Relationship therapy has this distinction from psychoanalysis in that it does not emphasize introspection or interpretation, it is not as time consuming or as expensive, and it does not require the same degree of psychological strength and sophistication of the patient. It differs from supportive psychotherapy in that it does emphasize a prolonged relationship, for example a therapeutic session once a week extending over many months or several years. It does not demand of the therapist as much intervention or active participation. In short, relationship therapy provides the opportunity for growth and change because of a continuing contact with a trained person who serves as a model around whom the patient's life can achieve a new organization and behavior pattern out of the process of learning and identification.

Supportive Psychotherapy: Supportive psychotherapy is designed to be more of a crisis therapy. Its goals are not to effect a basic change within the person's personality or behavior patterns. Rather it attempts to shore up a patient's faltering defenses which ordinarily are reasonably adequate, and to enable the patient to re-establish the *status quo ante.* It assists the ego to meet problems that are currently overwhelming. After the problems have been surmounted and the ego is once again functioning smoothly and comfortably, supportive therapy is, as a rule, no longer necessary and can be discontinued.

Dynamics of Supportive Psychotherapy

Regression: In times of crisis and unusual stress, most people tend to regress emotionally and psychologically. Attitudes and needs that would normally be a part of childhood become reactivated. For example, a person facing a critical issue may lose his self-confidence and may develop attitudes and feelings of helplessness, fear, guilt, and dependence. As a consequence of regression and the arousal of childhood attitudes and fears, the patient instinctively seeks out a person to whom he can turn for assistance, security, and dependency gratification. Appropriate to the reactivation of childhood feelings and attitudes, the individual would intuitively and unconsciously seek out a person who seemed to have those qualities which the patient, as a child, felt his parents possessed: strength, wisdom, security, et cetera.

Transference: The physician, because of the peculiarities of his professional role, consisting of things that are secret and of matters of life and death, fills this required role perfectly. In the patient's mind, he is not just another well trained, educated, or highly skilled person. Rather, the patient's infantile needs and wishes, once again unconsciously focused on omnipotent and omniscient figures of childhood (father or mother), are displaced onto the figure of the physician, creating in him a person with ususual attributes and powers for helping, healing, and forgiving, and, one should also say, hurting! This in psychiatric terminology is referred to as the transference, meaning that a person in the present is treated as if he were a person in the patient's past life.

This, then, is the emotional climate and situation that exists in the doctor-patient relationship. The physician has far more significance than he usually realizes. He also has far more power than he usually appreciates. His leverage is the deepest feelings of a person's mind and emotional life. As Binger[1] has said, "Because of the particular kind of authority with which we are vested by our patients, our words and deeds have a power enhanced far beyond the commonplace." He also says that physicians

> too often do not appreciate, as their patients do, the magic and power of their own words and acts. What is not appreciated by some doctors, though it is apperceived by their patients, is the power for good or ill that lies in the interplay of personalities. The doctor's words not only have wings but carry a charge of dynamite behind them.

The Application of Supportive Therapy

In providing supportive therapy, the physician must rely upon three things: (1) his presence, (2) his attitudes, and (3) his words.

The Physician's Presence: No person who occupies an influential position should discount the importance of his presence. Physicians who have a busy practice frequently pass off many routine treatment procedures to their nursing assistants. Some of this is all right. But from time to time the patient needs to see the physician, hear his voice, and feel his touch. The Bible tells us that the sick woman, with an issue of blood for 12 years, wanted only to touch the hem of Christ's garment and from Him to draw healing, strength, and virtue. Zaccheus climbed a tree that he might see Christ. The importance of seeing the significant object, hearing his voice, and feeling his presence is a powerful source of strength, support, and security. During war, the presence of the medics in the field adds a great sense of security to the combatants. They feel that in their hour of need they will be cared for. All people need to draw strength and a sense of identity from figures who are symbolically significant. As the masses turn to their president or their king, a symbolic father, and will stand for hours to catch a glimpse of him in a passing parade, so the patient turns to and looks for the presence of his physician.

All great physicians have a commanding and an influential presence. Farrar[2] in recounting his experiences with Osler, says of him,

> When Osler approached a patient's bedside, his very presence brought healing. His silent downward glance (at the bedside) was a cheerful communication and his voice partook of the quality that Richard Grant White long ago characterized in a tribute he paid to a great singer, of whom he wrote: "Her voice is vocal velvet!"

Farrar goes on to say of both Bernheim and Osler,

> Each of these great physicians brought with him when he entered the ward an atmosphere of confidence and com-

fort. The voice of each, as his nature was, in converse with patients was "ever soft, gentle and low," and that too was a natural and not a studied part of his own (Osler's) psychotherapy.

Israel[3] illustrates how another outstanding doctor was aware of the value of his presence. He says,

> The master gynecologic surgeon, Victor Bonney, impressed visitors who had come to observe his surgical dexterity by his cheery, social-minded ward walks. With a deft pinch of the cheek here and a quick chuck of the chin there, each gesture delivered to the patient with a ringing "Good morning, dearie!" and followed by a genuine question concerning her husband's gout or the effect of yesterday's storm upon the roses in her garden, he made effective rounds. Bonney's knowledge of and interest in his patients' affairs bespoke the wisdom of onemanship — he knew the unity of person and illness.

The child in a darkened room, an elderly confused patient in a strange situation, a patient facing surgery, a difficult life situation, or death needs the presence of a significant person who has symbolic significance at the deepest emotional level.

Knowing, then, the meaning of the physician to patients in crisis, his presence takes on new and added therapeutic significance. Presence can be and is therapy.

The Physician's Attitude: It has become increasingly evident that the physician's attitude, even though unverbalized, can be an extremely important therapeutic tool. It is common practice now in many psychiatric centers to evaluate a patient's emotional needs and then prescribe for the treatment personnel the attitude they should use in the relationship with the patient. An attitude can be supportive or destructive.

A variety of attitudes can be used in one's attempt to be supportive to a patient, depending on the situation and on the patient's needs. There are some attitudes that are basic and always essential such as respect for the patient as a person, interest in the patient and his problem, the manifest desire to understand and to be helpful, and to be non-condemning and accepting. Many patients have feelings of helplessness, rejection, and guilt. These basic attitudes help neutralize such feelings by fostering a sense of trust, confidence, and personal significance, all of which are so important in the recovery of a sick patient. To be listened to and attended to by an accepting significant figure (father) reassures one that he is no longer rejected or alienated — that he is not an outcast but is once again loved and valued.

There are other attitudes that a physician can use, depending on the situation and the needs of the patient. A common listing of these useful attitudes includes—*matter-of-factness, active or passive friendliness,* and *kind firmness.*

Matter-of-Factness: This attitude is not to be misconstrued with indifference. Rather, it is a non-anxious, unperturbed response to the patient's crisis and the patient's behavior. If in time of crisis the physician shows his concern in anxiety and alarm, the patient's cause is thereby damaged considerably. Matter-of-factness does not only serve to avoid the display of anxiety and over-concern, but it is also useful in avoiding the display of irritation, annoyance, or anger when a patient is being provocative and neurotically challenging. Many neurotic patients try to stir up their physician by making him feel responsible or guilty for problems that are solely their own. The physician must avoid being trapped by this maneuver. He must not become defensive. He must calmly identify the basic issues in the situation as well as the patient's responsibility. He should express a willingness to help in every way that he can but point out the limits of his responsibility.

Osler[4] extols the attribute of calmness and imperturbability in his famous address, *Aequanimitas.* It is still an important attitude for every physician to cultivate. Physicians should not react as anxious parents do when the child is injured or ill. We all know what a devastating effect this has on children. By reacting just the opposite to a patient's problem, illness, or crisis, we are undoing what might have been done earlier in the patient's life, and we become a source of strength and stability. A physician's power of iatrogenicity exists in the attitude of anxious concern as well as in what he says.

Active and Passive Friendliness: To be recognized, to be received with a warm smile, to have someone take an active step forward, with a firm handshake and meaningful salutation, can be of great therapeutic value. We are told that a vital phase in the organization of the infant's personality — a phase that enhances the development of confidence, outgoingness and increasing exploration — is the phase that occurs at about the third month of life and is referred to as the "smiling response."[5] The infant at this period has a dim awareness of his mother. He searches her face and "looks" for tangible evidence of love, kindness, and acceptance. When she smiles, it reassures the infant and he smiles back in delight. This is a period of primitive trust and confidence, and her smile encourages the infant in his further development.

Many patients who are basically insecure, who find it hard to trust, who are too fearful to take the initiative, who would without assistance sit in the corner passively and lonely, need someone to draw them out. This is what an attitude of friendliness is designed to do. Active friendliness means that the physician is going to take that extra step or show that extra thoughtfulness in striving to reassure and draw his patient out. Passive friendliness attempts to display equal warmth and acceptance but encourages the patient to take some initiative on his own, to try his own wings, and to learn that it is safe and satisfying to be more independent and aggressive.

Kind Firmness: As a good father needs to show strength and to set limits on his children's behavior on occasions, so are there occasions when a good

physician needs to be firm in his leadership and management of his patients. Kind firmness would approximate the "authoritative approach" used routinely by some physicians. However, not all patients should be managed at all times this way because it tends to foster dependency and to stifle growth. But at times a patient who is in a period of great anxiety and instability might need a firm hand and might need to be actively told what he should or should not do. Some patients in a crisis welcome being told what they can or cannot do. For example, a compulsive, overly conscientious person, who is threatening his health by overwork, may be able to change his behavior pattern if his physician firmly sets limits for him. The patient then does not need to feel guilty because he can say to himself, my physician (father) not only gave me permission to slow down but he insisted that I do so. In many psychiatric disorders, ranging from guilt-ridden patients, poorly controlled manic patients, to spoiled, undisciplined patients, unyielding firmness might be the patient's salvation.

The Words of the Physician: Words are an instrument of the physician. They implement what he already stands for in the patient's unconscious mind. Without the already established relationship and its unconscious significance, words would have much less influence. However, because of the powerful emotional leverage the physician has, it is important that he measure his words carefully. Thoughtless words can do infinite harm, while the appropriate word that is well-timed can do great good.

Words can be used for some of the following purposes: to reassure an unnecessarily anxious person; to explain and clarify the meaning of symptoms; to identify certain problems and behavior as being common among all human beings, thus enabling the patient to feel he is not alone in the mistakes he has made or in the conflicts he has experienced; this is referred to as softening the sense of guilt through the process of universalizing; to persuade and to encourage; and, with caution and good sense, to give advice.

Patients wish to please and to be accepted. They want to obey the physician. They want to believe. Therefore a physician, because of his role and because of the patient's basic attitude, can in many instances "heal" through suggestion, reassurance, and persuasion. Through combinations of trust, belief, and faith and of the physician's attitude and words, many patients have been made well.

The Limitations and the Risks Of Supportive Psychotherapy

This kind of psychotherapy is indicated primarily for people in crisis but is also useful in chronically ill (psychologically and physically) patients for whom "curative" therapy is not possible. Patients who could benefit from more penetrating therapy, such as electroshock therapy, relationship therapy, or psychoanalytic therapy, should receive it. Also it should be remembered that supportive therapy should meet an acute (and in some instances a chronic) need. As soon as possible the patient should be encouraged to use once again his own assets and strengths and not to exploit the use of supportive therapy, which in the end will only lead to further decompensation and protracted dependency. The physician has the responsibility to gauge carefully his patients' strengths and resources and encourage their use as rapidly as is possible. Out of ignorance or for other reasons, both the physician and patients can abuse the use of supportive therapy. But this is true of all treatment measures. These warnings and qualifications concerning the use of supportive therapy in no wise reduce the fact that supportive psychotherapy is a major therapeutic instrument in medicine. When used with understanding, skill, and integrity, it can make the difference between a doctor and a great physician — a man whose patients will rise up and call him blessed!

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FOLLOW THE WAY OF WISDOM, and do unto others as you would do unto yourselves, heeding the voice of conscience, love, and compassion. — A. M. Dogliotti, Turin, Italy: Moral Dramas and Dilemmas in the Practice of Surgery, *Bulletin of the New York Academy of Medicine,* 41:1107-1116, November 1965.

Experimental Pulmonary Embolism

A Study of Serum Lactic Dehydrogenase Levels

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DO VAN SUU, M. D., and TEH CHENG HUANG, Ph. D., D. V. M.

IT HAS been suggested by Coon and Willis that pulmonary embolism may be the cause of as many as 47,000 deaths annually in the United States.[1] Death occurs suddenly and, in the majority of cases, within the first 12 hours after the attack.[2-4] During this short time, the diagnosis is usually difficult. Rosenberg found that the electrocardiogram may show significant changes in only 70 per cent of cases.[5] These changes may not be diagnostic but only suggestive of pulmonary embolism. Other methods of diagnosis such as x-ray, angiograms, and the measurement of alveolar CO_2 content may all be helpful. However, all of these methods have their limitations.

Measurement of the serum lactic dehydrogenase (L. D. H.) activity has been mentioned as an additional method of differentiating cases of myocardial infarction, pneumonia, and pulmonary infarction. The L. D. H. may be increased but the serum glutamic oxalacetic transaminase (S. G. O. T.) activity usually remains normal in cases of pulmonary infarction.[6,7] The following investigation was made to study the activity of these enzymes during the first 24 hours immediately, following experimental infarction, when the diagnosis is most difficult.

Method

Twenty-four dogs were used to study the blood chemistries and physiological changes following the production of artificial emboli to the lungs. The animals were first anesthetized with a single dose of intravenous sodium Pentothal®. A small incision was made in the neck over the external jugular vein. Emboli were then inserted into the jugular vein using aseptic technique. Emboli were made from 20 parts of barium sulfate and 80 parts of paraffin, which had been previously mixed and sterilized by dry heat. Another type of embolus employed the use of the dogs' own blood mixed with barium sulfate in the center of the clot. By producing clots or emboli mixed with barium, we were able to assure ourselves, by x-ray, that the clots had gone to the lungs. Size and number of emboli were recorded on each animal. Physiological changes were recorded, including the body temperature, respiratory rate, heart rate, and the electrocardiogram.

Chest x-rays were taken immediately after the introduction of the emboli to ascertain the presence of all emboli in the lung fields. Chemical changes were also studied including the arterial pH, pCO_2, pO_2, lactic dehydrogenase (L. D. H.), and serum glutamic oxalacetic transaminase (S. G. O. T.). Measurements of the chemical studies were recorded before the emboli were introduced and at intervals of one, two, four, six, 12, and 24 hours. Central venous pressure was also monitored by a catheter in the left femoral vein.

Results

A summary of the results is shown in Table 1. Three types of clinical reactions were produced depending on the number of emboli introduced into the jugular vein. This is the reason for dividing the animals into three groups. Both types of emboli produced a similar anatomical change by x-ray (Fig. 1). Physiological changes did not vary in the two groups of emboli. In Group I, ten or more emboli were introduced into the jugular vein. Since all the animals in this group died, we studied only seven animals. Five of the seven animals died within 30 minutes after the introduction of the emboli.

The first physiological change noted in each case was a rise in the venous pressure from a normal of

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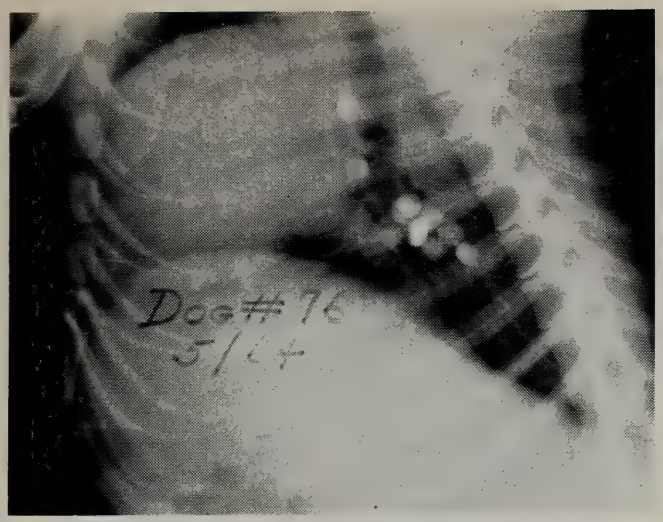


FIG. 1. *Lateral chest showing artificial emboli in lung.*

6 or 7 centimeters of water to as much as 40 centimeters of water. There was always acceleration of the heart rate and the respiratory rate. Heart rate usually increased 20 to 30 beats per minute while the respiratory rate increased from a normal of 13 to nearly 85 per minute. Cyanosis was conspicuous in this group. The arterial pH diminished and the pO_2 diminished. There were no changes noted in the lactic dehydrogenase or serum glutamic oxalacetic transaminase during the short observation period prior to death. The two animals that did not die within the first 30 minutes subsequently died within the first nine hours.

In Group II, all nine of the animals studied have survived the acute embolization. In this group, we had introduced less than 10 emboli and more than five emboli. This group did not manifest any immediate physiologic changes. The animals showed symptoms of pneumonia 24 hours following the embolization. These symptoms consisted of persistent dry cough, dyspnea, tachycardia, and elevated temperature. Three of the nine animals coughed blood starting as early as the third day. S.G.O.T. and L.D.H. studies varied from animal to animal. The elevation of these enzymes after pulmonary embolization was not as high as that seen after experimental coronary embolization in a previous study.[8] The highest L.D.H. recorded was 1480 on the third day in one animal. Another animal showed L.D.H. of 640, and two others were as high as 550. Serum bilirubin levels were observed and were not elevated in any of these cases. There was no elevation noted in any of the enzyme studies during the first 24 hours after embolization.

In Group III, we studied eight animals. All survived the embolization and were entirely asymptomatic. Each of these animals received less than five emboli per animal. The enzyme levels in this group were not elevated during the first 24 hours. In only one of the animals did the L.D.H. reach 520 on the third day. All animals lived normally as long as one year. At autopsy, emboli were embedded in dense connective tissue and fixed to the arterial wall in all cases.

Summary

Experimental pulmonary emboli were produced in 24 dogs. Physiological and chemical changes were recorded. A study of the serum L.D.H. and S.G.O.T. failed to demonstrate any change during the first 12 hours. Our study would indicate that these enzymes have not been clinically helpful in making a differential diagnosis between early pulmonary infarction, pneumonia, or myocardial infarction during the first 24 hours following the onset of the illness in the dog.

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TABLE 1. *Physiological and Chemical Changes in 24 Dogs Following Experimental Pulmonary Embolism*

	GROUP I		GROUP II		GROUP III	
	Lived	Died	Lived	Died	Lived	Died
No. of animals studied	0	7	9	0	8	0
No. of emboli introduced	10 or more		More than 5 and less than 10		5 or less	
Central venous pressure	↑		Normal		Normal	
Heart rate	↑		Normal		Normal	
Respiratory rate	↑		Normal		Normal	
Arterial pH	↓		Normal		Normal	
pO_2	↓		Normal		Normal	
Serum L.D.H.	No change		No change early		No change	
" S.G.O.T.	No change		↑ after 24-48 hrs.		↑ after 48 hrs.	
" Bilirubin	No change		No change		No change	
Clinical observations	All died in 30 minutes to 9 hrs.		Pneumonia on 1st day and 1/3 had hemoptysis by 3rd day.		Asymptomatic	

Pulmonary Hodgkin's Disease With Cavitary Lesions

HEMA GOPINATHAN, M.D., and LEE R. SATALINE, M.D.

WHILE mediastinal and bronchial lymph nodes are generally affected in Hodgkin's disease, involvement of pulmonary parenchyma occurs only in approximately 30 per cent of the cases.[1] Several distinct radiological types of intrapulmonary lesions have been described: (a) reticular patterns; (b) scattered infiltrations; (c) miliary foci; (d) massive lobar infiltrations.[2] Rarely, however, cavitary lesions may be observed, and in a collective analysis of 245 cases of pulmonary Hodgkin's disease, only 11 cases with cavitation were found.[1-6] An additional 19 individual cases have been reported in the world literature.[1,7,12] In all instances, other causes of pulmonary cavitation were excluded.

Recently we observed two patients with pulmonary Hodgkin's disease with cavitation. We wish to report these cases and to briefly review certain pertinent aspects of this uncommon complication of lymphoma.

Case 1

A 30 year old white woman was admitted to Lakewood Hospital on June 29, 1964, because of fever, anorexia, and a cough producing mucopurulent sputum.

At age 17 years, Hodgkin's disease was first diagnosed by lymph node biopsy. At age 23, she developed cervical and right paratracheal adenopathy for which she received radiation therapy (1300r and 1500r tumor dose to each respective area). There followed complete disappearance of the adenopathy. At 25 years of age, she developed pelvic and hilar adenopathy. She received radiation therapy (1000r) to the mid-line of the pelvis which was followed by a course of nitrogen mustard therapy (24 mg.). One year later, she developed bilateral inguinal and left cervical adenopathy. Tumor infiltration of both upper lung fields was also seen on x-ray. Radiation therapy (1900r) administered to each inguinal area resulted in regression of the adenopathy: chemotherapy with nitrogen mustard (26 mg.) following this, produced only a partial regression of the pulmonary infiltrations. Five months later, the bilateral pulmonary lesions had increased in size and she received radiation therapy (900r to each site). Complete disappearance of the infiltrations was observed in subsequent chest films. At this time, splenomegaly was first noted and the spleen was irradiated with 600r.

At 28 years of age, the patient developed obstructive jaundice which subsided following chemotherapy with Velban® (vinblastine sulfate, 5.8 mg.). Ten months later, the patient was re-admitted with a large nodular infiltration in the right middle lobe and smaller, scattered, bilateral pulmonary nodules. Chemotherapy with Velban (14.5 mg.) produced a complete disappearance of the lesions. At 29 years of age, fine nodular lesions recurred in both lungs. They again responded to chemotherapy with Velban (6.5 mg.). One year later, the patient developed a large consolidation in the left lower lobe, as well as left hilar adenopathy (Fig. 1). Within five months, a thick-walled cavity, with a fluid level, developed within the consolidation.

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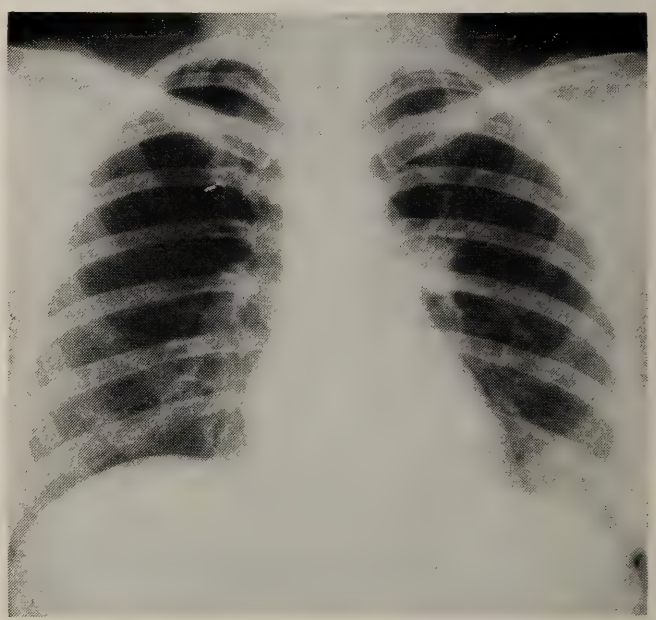


FIG. 1. *Chest x-ray of Case 1 six months prior to cavitation.*

A second, smaller cavity was observed in the left para-hilar region (Fig. 2). Her sputum became purulent but not foul smelling.

Following hospitalization, cultures of the sputum produced a mixed growth of commensal organisms but no pathogens. No fusiform or spirochetal organisms were seen on direct smear. Repeated sputum examinations and cultures for tubercle bacilli and fungi were negative. The intermediate tuberculin skin test was negative. No Reed-Sternberg cells could be demonstrated in the sputum. Her hemoglobin was 8 Gm. and the white blood cell count 13,000 with 93 per cent neutrophils, and 7 per cent

lymphocytes. She was placed on treatment with tetracycline, and postural drainage was instituted. Irradiation (2400r) and Velban therapy (16 mg.) resulted in a 50 per cent diminution in the size of the large cavity (Fig. 3). After discharge, subsequent chest films showed complete disappearance of the cavitations during a four-week period. Four months later, her x-ray shows no recurrence of the cavitations (Fig. 4).



FIG. 2. *Two cavitary lesions in Case 1.*

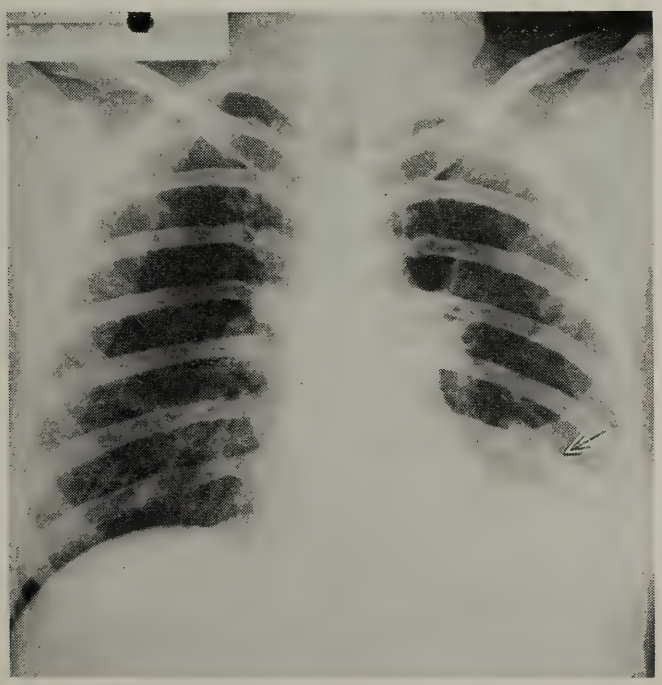


FIG. 3. *Reduction in size of cavities in Case 1 following treatment. Note the fluid level in lower cavity.*

Case 2

A 48 year old woman was admitted to Lakewood Hospital on September 2, 1964, because of anorexia and a nonproductive cough.

She had Hodgkin's disease of eight years' duration, which was first manifested in 1956 by cervical adenopathy. This responded to radiation therapy (1500r). In 1960, the patient developed right hilar and upper mediastinal adenopathy for which she received nitrogen mustard (30 mg.). Complete resolution was noted radiographically. One year later, she developed a pulmonary infiltration in the left para-hilar lung field and a right lower lobe consolidation with an effusion. Radiation to the left and right lung infiltrations (1600r and 1400r respectively) resulted in a 75 per cent reduction in the size of both lesions. The right pleural effusion was completely resorbed. However, a recurrence of both infiltrations was noted within six months. Again, they were irradiated (2200r and 2000r respectively) and complete resolution was noted within two months.

Nine months later, left hilar adenopathy accompanied by a para-hilar pulmonary infiltration was observed. Irradiation of the lesions (1400r) produced no substantial change. During the next four months the lesions further increased in size and chemotherapy with Velban (20 mg.) resulted in a partial regression.

In September, 1964, ten months after the last treatment with Velban, the patient was found to have bilateral lung infiltrations with cavitation in the left upper lobe (Fig. 5). The cavity appeared irregular and thick-walled by laminog-

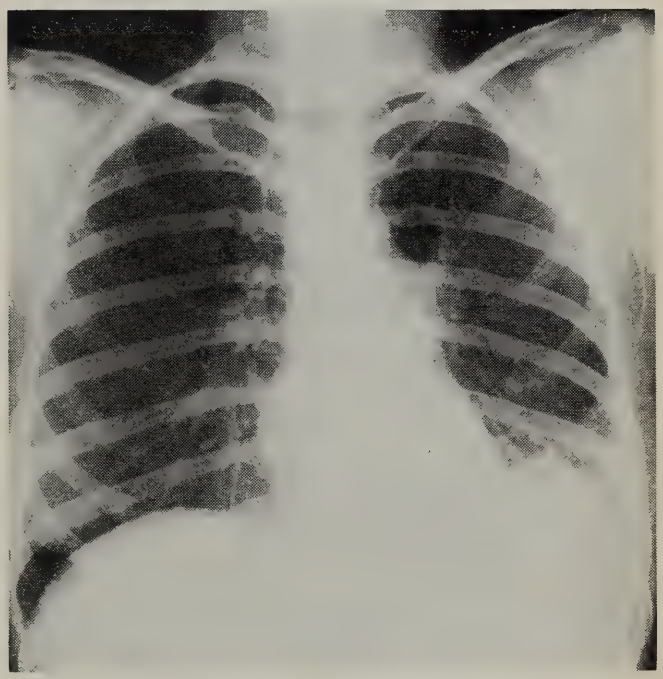


FIG. 4. *Disappearance of cavities in Case 1 four months later.*

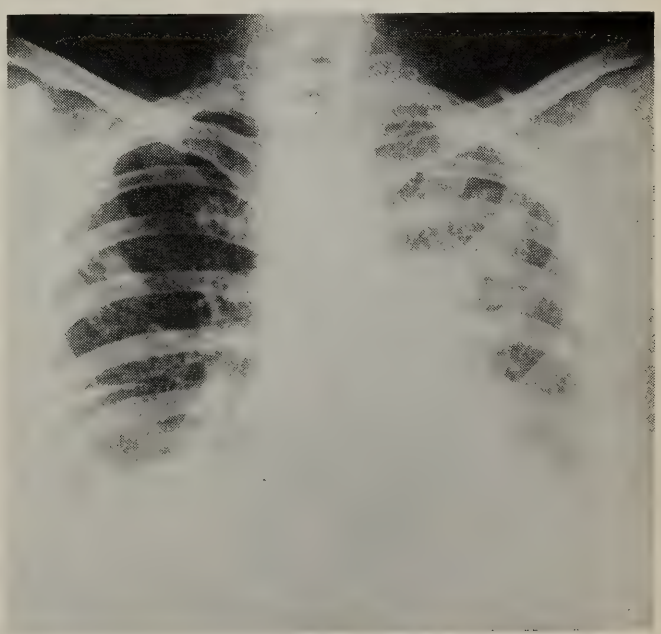


FIG. 5. *Left upper lobe cavitation in Case 2.*

raphy (Fig. 6). Sputum cultures grew out commensal organisms but were negative for tubercle bacilli. No fusiform or spirochetal organisms were seen in sputa smears. The tuberculin and histoplasmin skin tests were negative. Her hemoglobin was 10 Gm. and her white blood cell count 9,400 with 73 per cent neutrophils, 9 per cent eosinophils and 18 per cent lymphocytes. Chemotherapy with Velban (40 mg.) and antibiotics produced no substantial change in the lesions. Subsequent x-rays of the chest have shown an increase in the infiltrations, and, clinically, the patient has continued to deteriorate.

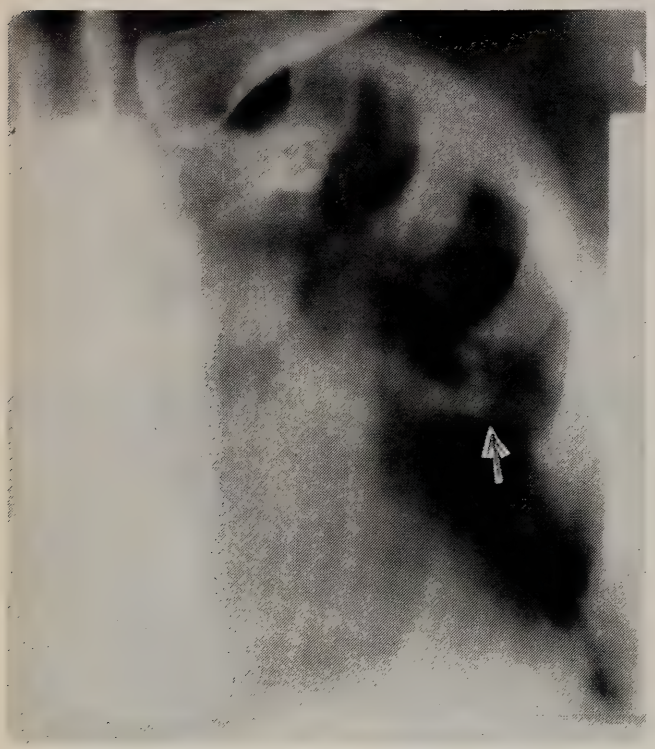


FIG. 6. *Laminogram of cavity in Case 2.*

Discussion

Although cavity formation was mentioned as early as 1888 by Claus,[1] the first detailed report was published by Vieta and Craver[1] in 1941. These authors described three cases of cavitation in a series of 134 patients with parenchymal lung involvement by Hodgkin's disease. More recently, Steel[6] reported four cases. There appear to be no specific signs or symptoms for cavitation since fever, weakness, and cough are common occurrences in Hodgkin's disease without cavitation. Radiographic studies would seem to be the best method for detecting pulmonary cavities, but as the cavities do not have any specific appearance which would distinguish them from other causes of cavitation,[8] diagnosis is one of exclusion.

Pulmonary cavitation in patients with Hodgkin's disease of the lung seems to occur more frequently in long-standing cases. In reviewing the literature, the average duration of the disease, prior to the development of the cavities, was 12 to 15 years. Furthermore, it would appear that life expectancy following the appearance of the cavities, is considerably shortened. This may be related to the increased resistance to the anti-tumor treatment which is noted at this stage. Although pulmonary involvement in Hodgkin's disease occurs with equal frequency in both males and females, the literature indicates there is a definite increase in the frequency of cavitation in females, the male to female ratio being one to five. The significance of this is unknown.

The cause of cavitation in Hodgkin's disease remains uncertain. Pulmonary cavitations are most frequently associated with granulomatous disease (tuberculosis, histoplasmosis, etc.); primary lung abscesses and primary or metastatic malignant tumors.[11] The not uncommon development of granulomatous infections in patients debilitated by Hodgkin's disease makes it imperative that these diseases be excluded by repeated sputum examinations and serologic tests. Skin testing may be misleading, as anergy is not uncommon with lymphomatous disease.

Primary lung abscesses result from partial necrosis of the lung parenchyma and most frequently occur in debilitated patients and alcoholics following aspiration and/or respiratory infections.[13] Neither patient had foul smelling sputum and spirochetal or fusiform organisms were not found in the sputa. Furthermore, no predominate pathogenic organisms were cultured, thus excluding putrid and so-called "nonputrid" lung abscess.[11] The roentgenologic findings and response to irradiation also mitigate against infection as the cause of cavitation in these two patients.

Cavitation occurring in malignant tumors may result from: (a) occlusion of the bronchus with subsequent infection and abscess formation; (b) central necrosis of the tumor following irradiation or chemotherapy; (c) breakdown of a rapidly expanding tumor which outgrows its blood supply.[14-15] In neither of these cases was bronchoscopy or bronchography performed, and some element of obstruction cannot be excluded. Peribronchial lymphatic involvement by lymphoma frequently compresses and occludes the bronchus.[2]

Tumor necrosis following antitumor therapy can be excluded as a cause of cavitation as the last course of treatment in both patients had been almost one year prior. We believe, therefore, that the cavitations resulted from necrosis due to an insufficient blood supply to a fast-growing tumor. Irrespective of size, the blockage of nutrient arteries by tumor cells, as has been demonstrated at autopsy, may severely compromise the tumor vascular requirements.[15]

There is no specific treatment for cavitation occurring in Hodgkin's disease. Drainage and appropriate antibiotic therapy following sputum cultures should be instituted. Radiation and/or chemotherapy may be necessary before adequate drainage can be established. Pulmonary resection has been performed in one case of primary Hodgkin's disease of the lung, but no follow-up report was given.[12] However, resection appears of doubtful value in generalized

lymphoma as the prognosis appears to be considerably worse following the development of cavities.

Synopsis

Involvement of the pulmonary parenchyma occurs in approximately 30 per cent of the cases of Hodgkin's disease. The pulmonary lesions may present several radiological patterns, the rarest of which is cavitation. Approximately 30 cases have been mentioned in the literature.

In this paper we report two women with long-standing Hodgkin's disease, who developed pulmonary cavitations. In one patient the cavitation responded to combined radiation and chemotherapy.

Pulmonary cavitation in Hodgkin's disease appears to develop more frequently in long-standing cases and in women. The clinical and radiological findings are not specific. The most frequent causes of lung cavitation are: (1) granulomatous disease; (2) abscess formation, and (3) tumor necrosis. The diagnosis of cavity formation in Hodgkin's disease is mainly one of exclusion. Treatment consists of drainage, antibiotics and chemotherapy, and/or radiation.

Acknowledgments: We wish to thank Dr. Vishwa Kapur, Department of Medicine, Cleveland Metropolitan General Hospital, for his helpful criticisms while preparing this paper. Acknowledgments are due Dr. Arthur F. Young for the use of his cases and to Dr. H. R. Claypool for his guidance in the radiological study and therapy of these patients. Mrs. Dorothy Jorgens was of great help in compiling the bibliography.

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SOME DISPOSABLE SYRINGES CAN YIELD CONTAMINANTS.— Disposable syringes may contaminate aqueous solutions contained in them. The source of this contamination is the rubber portion of the plunger according to Mario A. Inchiosa of the Harvard Medical School.

Writing in a recent issue of the American Pharmaceutical Association's *Journal of Pharmaceutical Sciences**, Dr. Inchiosa points out the significance of this contamination in view of the extensive utilization of disposable syringes, not only for administering injections but also for transferring solutions and blood in both clinical practice and in the laboratory. Because of prepackaging procedures, solutions may remain in these syringes for long periods of time.

Two commercial brands of disposable syringes (selected at random and designated as types A and B) were subjected to various extractive procedures. The parts of the syringes were soaked in water or normal saline at room temperature for varying periods of time. The plastic parts of these particular syringes yielded no extractives. However, the rubber portion of the plunger contained water-soluble contaminants which were detected by absorption of ultraviolet light.

2-(Methylthio) benzothiazole was the principal contaminant extracted from type A plunger. Small amounts of other compounds were detected but not identified. The compound has insecticidal action and was shown to be an effective spray in a concentration of 0.2 per cent against three of four species. Following 42-hour extraction of the type A plunger, the concentration of this compound reached 0.1 per cent in the extraction solution.

The extract from the type B plunger has not been identified, but was shown to be different from that extracted from the type A plunger. The contaminant in the type B plunger inhibited the *in vitro* hydrolysis of adenosine triphosphate by cardiac actomyosin.

Glass syringes subjected to the same procedures yielded no contaminants. — ABSTRACT furnished by the American Pharmaceutical Association.

*Inchiosa, M. A., Jr.: *J. Pharm. Sci.,* Vol. 54, No. 9, p. 1379, September (1965).

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

COLIN R. MACPHERSON, M.D., *President*

PRESENTATION OF CASE

FIRST ADMISSION: This Negro man, aged 35 years, was first seen at Ohio State University Hospital on November 11, 1963, when his family physician sent him in for evaluation of swelling of his legs that had been present for one year and had been unresponsive to diuretic therapy and digitalis.

At age 3, the patient had received trauma resulting in kyphoscoliosis and necessitating spinal fusion at age 14. He had always had shortness of breath on exertion and used two pillows to sleep. There was no history of chest pain, cyanosis, angina, hemoptysis, or pneumonia. From 1958 to 1961 he had gained 50 lbs., with worsening of his dyspnea on exertion, and swelling of his legs. On treatment with digitalis and diuretics he lost 40 lbs., but in November 1962 he noted the rather sudden onset of leg swelling that gradually progressed to the time of admission, with more rapid progression in the last three months.

Physical examination revealed marked kyphoscoliosis. His weight was 165 lbs. The neck veins were distended at 45° with A and V waves present. The heart rhythm was normal with a rate of 90. The blood pressure was 120/80. There were no murmurs or gallops. The pulmonic second sound was increased with a fixed split. Rales were heard in both lung bases. The abdomen was distended and a fluid wave was elicited. The liver was nontender and its edge was palpable 10 fingerbreadths below the right costal margin. There was 3 plus pitting edema of both legs, slightly more marked on the right, with scattered blebs and some questionable cellulitis. The penis was edematous. There was questionable cyanosis of the nail beds.

Laboratory Studies: The hemoglobin was 19.7 Gm., the hematocrit 66 per cent; the white blood cell count was normal with a normal differential count. The urine was normal except for 5 mg. of protein. The blood urea nitrogen was 37 mg. and the creatinine 2.5 mg. per 100 ml. The direct van den Bergh was 2.1 mg., the total bilirubin 3.1 mg. per 100 ml. Sodium, potassium, and chloride values were normal; the CO_2 combining power was 36 mEq/liter. Liver function tests were normal. The prothrombin time was 60 per cent of normal. The alkaline phosphatase was 9 units. The total protein was 7.1 Gm. per 100 ml. (albumin 3.3, globulin 3.8 Gm.). The serologic test for syphilis was nonreactive. A tuberculin skin test was negative. The venous pressure was 390. The electrocardiogram revealed right ventricular hypertrophy and incomplete right bundle branch block. The intravenous pyelogram was normal. Cardiac fluoroscopy revealed right ventricular enlargement with pulmonary congestion and a gibbus at the cervicodorsal level.

The patient was treated with digitalis and various diuretics and had one phlebotomy. This treatment produced a weight loss of 8 lbs. in 23 days. His dyspnea improved slightly. At the time of discharge his left leg was slightly larger than the right.

After his discharge, he was followed in the Outpatient Department and during the first month he lost 25 lbs. on oral diuretics, but from January of 1964 until his second admission he gradually gained 15 lbs. Pulmonary function studies showed 33 per cent timed vital capacity.

Second Admission

In July 1964 he was readmitted to University Hospital with increased shortness of breath and abdominal swelling. One week prior to admission he developed a cold with a cough productive of yellow sputum. There had been no hemoptysis. He also noted anorexia and a watery diarrhea for three days, associated with increase in abdominal girth and leg edema. He denied any chills or fever.

On admission he was in mild respiratory distress with a respiratory rate between 26 and 30 per minute.

Presented by

- **C. D. Schoenfeld, M.D., Columbus, and**
- **C. R. Macpherson, M.D., Columbus.**

Edited by Dr. Macpherson.

Submitted December 21, 1965.

His temperature was 98°F. The blood pressure was 120/90, the pulse 110. There was obvious cyanosis of the lips and nail beds. There was marked kyphoscoliosis. The neck veins were distended at 90°. Generalized rales were heard over both lungs. The heart was in normal sinus rhythm. A right ventricular heave was present. No murmurs were heard. The liver edge was palpated 15 cm. below the right costal margin. The abdomen was nontender and distended, but no fluid wave was elicited. There was 4 plus pitting edema of both legs to the presacral area.

Laboratory examinations showed a hematocrit of 70 per cent, hemoglobin of 21 Gm.; the white blood cell count was 10,800 with a normal differential count. The urine was normal. The prothrombin time was 34 per cent of normal. The blood urea nitrogen was 51 mg., the creatinine 2.4 mg., and the fasting blood sugar was 82 mg. per 100 ml. The serum electrolytes were normal, the CO_2 41 mEq/liter. Sputum cultures were noncontributory. The electrocardiogram was unchanged from that of the first admission.

Treatment of the patient was started with procaine penicillin, 600,000 units every 14 hours, in addition to digitalis and various diuretics. He lost 13 lbs. in the first three hospital days. Because of thick sputum, increased shortness of breath, and a semicomatose state, tracheotomy was performed on the second hospital day, and he was placed on a Bird respirator. Arterial gas studies done on the following day showed an O_2 saturation of 99.5 per cent, a CO_2 content of 99.5 per cent. The pH was 7.27, the pCO_2 was 96. He was on the Bird respirator at this time, breathing 40 to 60 per cent oxygen.

On his fourth hospital day a Rochester catheter broke off at the hub and it was believed that the plastic end had remained in the patient's arm. An x-ray showed no foreign body present in the left upper arm or elbow. A cutdown was performed immediately above the site to prevent any dislodgment. On his sixth day he had two episodes of ventricular fibrillation. The first converted, but the second did not respond to resuscitative efforts and he died. He had remained afebrile throughout this stay.

CLINICAL DISCUSSION

DR. SCHOENFELD: One of the ways in which a person faced with the task of discussion at a clinicopathological conference can tell whether he is doing well is to go to the library and find that all the recent journals containing the references he wanted to see are missing. This is what happened to me, so I had to go to the older literature. The forty-sixth aphorism of Hippocrates states, "Such persons as become humpbacked from asthma or cough before puberty die." In this interesting man's work there is this other quotation:

> In those cases where the gibbosity (that is, the hump) is above the diaphragm, the ribs do not expand properly in width, but forward, and the chest becomes sharp-pointed and not broad and they become affected with difficulty of breathing and hoarseness, for the cavities which inspire and expire the breath do not attain their proper capacity.

We know that this is a classic disease and I think that we are facing today a classic example of kyphoscoliotic cardiorespiratory failure, the heart failure of the hunchback.

This was a relatively young man when he died, 35 years of age. He had been sick for approximately a year with leg swelling. The deformity of his thorax began at the age of 3 years, and a spinal fusion was done at the age of 14 years. Apparently this did not result in adequate correction, as is so often the case when there has been such a long delay. He had always had shortness of breath. In the three years prior to admission he gained 50 lbs. but lost 40 of it with digitalis and diuretics. We are not told the size of the heart and this is not surprising. One would expect that they couldn't tell the size by physical examination.

Laboratory data give us some clues. He had marked polycythemia with a normal white count and a normal differential, indicating that this is probably a secondary polycythemia. The elevated blood urea nitrogen, creatinine, and liver function tests I am going to attribute to the presence of heart failure and not discuss them any further. The electrocardiogram showed signs of right ventricular enlargement. The venous pressure was what we would expect it to be. His left leg was slightly larger than the right. He did pretty well after he was sent home, losing another 25 lbs. of weight, but he began to gain it back. Pulmonary function tests showed a marked decrease in his breathing capacity.

Then in July of last year he caught cold and had *yellow* sputum. He began to have anorexia and a watery diarrhea. He was admitted and shown to be in mild respiratory distress. I doubt that it was mild. He was now quite cyanotic and had evidence of heart failure. From the laboratory findings he was even more polycythemic, yet his white count was still normal. His carbon dioxide combining power was elevated. The electrocardiogram was unchanged. The patient then lived for about six days. He lost weight but became comatose and the arterial blood gases are highly interesting. The oxygen saturation is normal or supernormal, indicating that the Bird respirator was getting some air down there or he was getting it down there himself. However, the carbon dioxide content and the carbon dioxide tension in his arterial blood were markedly increased, indicating that many of the alveoli, most of them in fact, were not being ventilated.

Then we have the red herring. A Rochester catheter broke off at the hub. I would choose to ignore this. These little plastic things have been broken off within the right heart many times and have not caused any particular disability. They just lie along the pulmonary artery and don't do much of anything. Then our patient, still in his semicomatose state,

died suddenly with ventricular fibrillation and did not respond to resuscitative efforts.

I don't think there is any question about the diagnosis, but I think the basis for our discussion should be the nature of this disease.

The etiology of the kyphosis is interesting. Eighty per cent of cases in the orthopedic literature are now classified as "idiopathic." A large number used to be due to polio. An equally large number were due to tuberculosis in childhood. Often children are examined and told that they don't have enough scoliosis to worry about. This is a rather dangerous thing because most of them will progress. The idiopathic and general varieties do progress relentlessly. They all have small lung volumes; the vital capacity is reduced; the residual volume is reduced; the total lung capacity is reduced. Second, the work involved in breathing is very great. The work is increased by a factor of four or five times.

Work of Ventilation

It has been shown that the patient with kyphoscoliosis must exert a greater pressure difference in order to distend his lungs. In normal people, about 20 per cent of the work they do in breathing is to overcome the elastic resistance of the chest; the remaining 80 per cent is to overcome the elastic resistance of the lungs. In these patients the ratio may be virtually reversed, so that 50 to 60 per cent of the work they do in breathing is to move the chest. What else do they do? They breathe rapidly and very shallowly. Their vital capacity is usually a third to a half normal. What does this do? The dead space in most of us is about 150 ml. We cannot change our dead space at will. They take more breaths and shallower breaths, but the dead space thwarts the mechanism. It leads to an inadequate delivery of air to the alveoli — alveolar hypoventilation. They don't deliver enough oxygen to the arterial blood, so there is arterial hypoxemia. They don't extract enough CO_2 from the venous blood, so that some goes on past the alveolus; the carbon dioxide content and tension in the arterial blood go up. He has now much the same situation as the patient with emphysema.

Carbon Dioxide Narcosis

Next, he becomes insensitive to carbon dioxide. This is an important factor. The main stimulus to breathing is the retention of carbon dioxide. If you are faced with large concentrations of this you can't go around hyperventilating all day. The brain protects itself from becoming insensitive to carbon dioxide administration. When the CO_2 goes up too high these patients no longer respond to it and they develop carbon dioxide narcosis. They become somnolent and if you bring them into the hospital and give them oxygen they get pink and they go to sleep. Carbon dioxide narcosis doesn't respond to simple oxygen administration; in fact, this is the most common cause of death in people with kyphoscoliotic heart disease. They are given Demerol® or morphine, and oxygen to breathe. These people are dependent upon their arterial hypoxia to keep them breathing. If you take that away, they lose the stimulus to breathe. Also they are so very sensitive that if you depress their respiratory centers with narcotics, then virtually they have no drive toward breathing. The literature is full of cases that said, "The patient received ½ grain of morphine (or 100 mg. of meperidine) and died two hours later."

Arterial Hypoxia and Sequelae

The other thing they have is arterial hypoxia and it causes pulmonary hypertension. This may not be evident at rest, but with mild exercise it increases. Another response to hypoxia of course is polycythemia. Polycythemia leads to an increased blood viscosity that may be a factor in pulmonary hypertension. We are not sure.

So the patients can be divided into three groups. First, there is the large group of patients who show no symptoms. These are people who have a scoliosis of less than 100°. Kyphosis in itself causes little respiratory difficulty until it becomes very severe. The scoliosis is essential. The second group patients have dyspnea on exertion as their only cardiorespiratory symptom. Patients in the third group have cor pulmonale and are usually cyanotic.

Treatment

What can we do to treat them? We can attack the problem of alveolar hypoventilation by using a Bird respirator. You can apparently increase the tidal volume at no energy cost. They should not receive, when they are severely ill, pure oxygen or even 40 per cent oxygen; they should only receive intermittent positive pressure breathing. If they are infected, of course we can treat them with antibiotics. They respond to digitalis and diuretics just like anybody else. The increased blood viscosity and blood volume that go along with polycythemia can be relieved by phlebotomy. This is one group that should be phlebotomized to as near a normal hematocrit as possible. Many of these patients used to die within a year after they became cyanotic. The more recent reports indicate that they can be carried three, four, five and six years and a few even longer.

These patients at autopsy often have pulmonary emboli or pulmonary thrombi of long or short duration. I think that may well have happened to our patient here — something made him worse in a hurry while he was under good medical management. So I would predict that we will find all the usual changes with kyphoscoliotic heart disease, and that in addition we may find severe bronchial infection and possibly pulmonary emboli or thrombi.

DR. CARHART: Would you anticoagulate these people when they are in serious difficulties, with polycythemia?

DR. SCHOENFELD: Nobody has much experience, but I suspect we should anticoagulate as well as do phlebotomies.

MEDICAL STUDENT: What about evaluating the children? I presume that's where you have to try to prevent kyphoscoliotic heart disease?

DR. SCHOENFELD: This is an excellent point. It has been shown that the patients who have no more than 40 per cent decrease in their vital capacity do not go on to develop cardiorespiratory difficulties. So that a good way to follow the patient when he is a child is to do repeated vital capacities upon him. If this begins to diminish, then we should seriously consider a surgical approach to try and stabilize him.

CLINICAL DIAGNOSIS

1. Kyphoscoliotic heart disease, traumatic origin.
2. Bronchopneumonia.
3. Cor pulmonale.
4. Pulmonary emboli.

PATHOLOGIC DIAGNOSIS

1. Kyphoscoliotic heart disease, traumatic origin.
2. Bronchitis.
3. Pulmonary emphysema.
4. Pulmonary thromboemboli.
5. Cor pulmonale.
6. Cardiac cirrhosis.
7. Sickle-cell trait.
8. Stress ulcers of stomach.

DISCUSSION OF PATHOLOGY

DR. MACPHERSON: Dr. Schoenfeld's discussion was very complete, but there are a few additional points that I think are of some interest. One observation in the literature is that the kyphosis is much more significant if the gibbus is to the right rather than to the left. Nobody seems to have a good explanation for this, but there is probably more obstruction to the free passage of air and to the aeration of the alveoli. However, these patients are very difficult pathologically because if you take a long-standing pulmonary lesion you get secondary vascular changes. This patient indeed showed these features. In addition, one of the consequences of lesions leading to inadequacy of pulmonary function is stress ulceration of the stomach.

There is a highly significant statistical correlation between pulmonary disease and gastric ulceration or duodenal ulceration. In this case there were two ulcers in the stomach which we assume to be stress ulcers. He also showed a remarkably active bone marrow for a man of his age. As possible explanations of his hemolysis and bilirubinemia, we have two factors. Patients with chronic pulmonary disease develop congestion of the liver and eventually a cardiac cirrhosis, which he had. In addition he had a sickle-cell trait which was not picked up during life but which shows up in some of the sections.

The first of the pictures shows one of the primary lesions and you will notice there that he had disruption of the pulmonary parenchyma. These are the broken off alveoli. Here is a small thrombus in a vessel, and here he has a very abnormal vessel with marked thickening of the muscular wall and some thickening of the endothelium. He also has definite thickening of the interalveolar septa. So there is an emphysematous change in the lung which will of course further embarrass his expiratory exchange, and the vascular changes will further embarrass his cardiac reserve. This is a really vicious cycle at this point.

The next slide shows quite a bit of hemorrhage into the alveolar spaces. You will notice that the red cells are irregularly shaped: they are crescent-shaped, they are spiked, and here you have a sickle — a classical crescent shape. The picture is sufficiently characteristic to diagnose sickle-cell trait. He obviously didn't have sickle-cell anemia with 20 Gm. of hemoglobin, but there is no law that says that you can't have polycythemia on top of a sickle-cell trait. I would think from the number and distribution of the thrombi that these were probably incidental and did not contribute very greatly to his death.

Here we have a picture of the trachea. You will notice that the lining of the trachea shows massive infiltration with red cells, edema, and acute ulceration of the epithelium with some evidence of metaplasia. This was taken from near the tracheostomy site. Frequently we don't realize that the various pieces of equipment we insert do produce changes — some of them significant, some of them not. In this case you don't see the associated infection which you often see. He did have bronchitis but he did not have bronchopneumonia, and I don't think infection played a significant part in his terminal stages. It may well have done so a little earlier.

His liver was definitely cirrhotic to the naked eye, and the histologic pattern is that of diffuse intermingling of fibrous tissue with the trabeculae of the liver. Bile stasis is not a prominent feature. This is the picture of cardiac cirrhosis.

The only other point that remains to be dealt with is the question of the catheter. The piece that broke off was 3 cm. in length and at the autopsy the catheter was found in the pulmonary artery. The presence of a catheter or other foreign body in the pulmonary artery does not generally lead to arrhythmias. However, foreign objects in the outflow tract of the right ventricle characteristically lead to arrhythmias. Under experimental conditions it can be shown that a shower of artificial emboli, if injected into experimental animals, causes an increase, in some cases a sudden increase, in pulmonary artery pressure. Since the catheter was lying loose in the pulmonary artery,

somewhere close to the right ventricular outflow tract, it is possible that the catheter did trigger off attacks of ventricular fibrillation. It might have given rise to minute emboli from intimal abrasion. There is no way we can prove it.

This is then a case of classical kyphoscoliotic heart disease. There were vascular changes in the lung that were probably part of the normal progession of the disease. He also showed stress ulcerations of the stomach and a coincidental sickle-cell trait which was probably not of any great significance except that it does account for the hemolysis. Finally, he had a cardiac cirrhosis which was interesting because at autopsy the liver edge was still 10 cm. below the costal margin. With kyphoscoliosis you get displacement, and actually his liver weighed only 1200 grams. So he had a small, cirrhotic liver that was pushed down a long way by his anatomic distortion.

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Adequate Prenatal Care

"Be Good to Mother Before Baby Is Born"

ANTHONY RUPPERSBERG, JR., M. D.*

THE primary purpose of this column is to present material obtained from experiences gained through operation of the Ohio Maternal Mortality Study, for the information and education of Ohio physicians who practice obstetrics.

At a meeting last year of The Council of the Ohio State Medical Association, as the author delivered the official annual report of the Committee on Maternal Health, members displayed maximum interest in the "Ohio Study." One member of Council asked questions concerning "Child Outcome" in maternal deaths, while another posed a question related to the significance of prenatal care connected with maternal mortality.

Based upon these points of inquiry, this article is devised to present a preliminary survey of statistics from the Ohio Maternal Mortality Study relative to "Child Outcome" and "Prenatal Care" associated with maternal mortality. The article is not to be considered as a primary personal accomplishment of the author, but rather as a tribute to the committee and numerous other physicians throughout Ohio, who have contributed richly to the study in both time and effort.

Child Outcome

By action of the OSMA House of Delegates, April 23, 1953, and follow-up action of The Council, January 10, 1954, the Committee on Maternal Health operates a continuous *Maternal Mortality Study*[1] throughout the 88 counties of Ohio. Essentially designated to study *maternal* deaths, the mission of the committee has not been altered.

However, when the IBM Data Processing System was developed for the study in 1958, a small segment of the code sheet was designated to collect a modest amount of information concerning the child, or "fetal outcome."

In this project a search was made for the number of maternal deaths and their primary causes, during an eight year period, 1955-1962 (see Tables 1 and 2). As stated previously in this column, "hemorrhage" holds a questionable honor as the leading primary cause of maternal deaths in Ohio.[2]

TABLE 1. *Category of IBM Cards, 8 Years, 1955-1962, Ohio Maternal Mortality Study*

Rejects (No Case)	21
Cases Incomplete	57
Nonmaternal Deaths	177
Maternal Deaths	643
Undetermined	2
Total	**900**

TABLE 2. *Classification of Cause of Death, 643 Maternal Deaths, 8 Years, 1955-1962, Ohio Maternal Mortality Study*

Hemorrhage	165
Infection	120
Toxemia	75
Other Causes	283
Total	**643**

Further studying the 643 maternal deaths, it was found that 280 babies were born alive; of these, two died a neonatal death (Table 3). While 123 mothers died undelivered, postmortem cesarean sections delivered *fifteen* living babies (included in the 280). Eleven stillborn babies occurred in this series. The ectopic pregnancies, abortions, etc., are omitted from comment.

TABLE 3. *Child Outcome, 643 Maternal Deaths, 8 Years, 1955-1962, Ohio Maternal Mortality Study*

Not Recorded	5
Pt. died undelivered	123
Live Births (Neonatal Deaths 2)	280
Stillborn	11
Excluded	224
Total	**643**

In this study, terminology and classification of gestational age as stated are based upon fetal weights, in accordance with modern accepted standards.

The majority of the mothers, 352 (54.7 per cent) reached term or near term in their gestation at the

*Dr. Ruppersberg, Columbus, is Chairman, Committee on Maternal Health, Ohio State Medical Association.

Submitted January 17, 1966.

time of delivery or death. On the other hand, 135 of the 643 women (20.9 per cent) carried a "premature" gestation at the time of death or delivery (Table 4).

TABLE 4. *Classification of Gestation, 643 Maternal Deaths, 8 Years, 1955-1962, Ohio Maternal Mortality Study.*

Not Recorded	2
Immature (500-1000) Gm.)	21
Premature (1001-2500 Gm.)	135
Term (2501 Gm., or more)	352
Ecoptic, Abortion, Mole, etc.	133
Total	**643**

Prenatal Care

Currently the medical profession is having attention drawn more and more towards the importance of good prenatal care. This especially pertains to the segment which provides obstetric care for the pregnant or puerperal patient. Since its incipience, the Committee on Maternal Health has placed emphasis on *this* phase of obstetric care. "**Adequate prenatal care**" has been described in "Guiding Principles for Obstetric Care"[3]; developed by the Committee, the precepts provide a yardstick upon which variations in care are measured. Emphasis has been directed not only toward the *prevention of maternal* deaths, but in support of "Maternal Health in Ohio," to the happy end that all mothers might lead a normal life, fulfilling the pleasant duties of a mother raising a family.

To summarize a few facts from data available, the cases were examined for certain information relative to prenatal care received by the patient before her death. Our data indicate 305 patients received *adequate* prenatal care in this series (Table 5). Of these 123 died undelivered. One hundred eighty-two living babies were delivered from the 305 mothers; this figure, in comparison, is at least three times the number represented by patients who received either *no* prenatal care or *inadequate* care.

TABLE 5. *Prenatal Care and Child Outcome, 643 Maternal Deaths, 8 Years, 1955-1962, Ohio Maternal Mortality Study.*

Prenatal Care from Available Information	No. of Cases	Patient Died Undelivered	Live Births
Care Not Reported	62	22	14
No Prenatal Care	63	9	27
Adequate Prenatal Care	305	44	182
Inadequate Prenatal Care	122	22	57
Excluded	91	26	0
Total	**643**	**123**	**280**

Discussion

It is obvious to the author, as well as to the reader, that although the statistics presented above are not conclusive, we may glean certain valid impressions from a study of the figures. (1) Omitting the "excluded group," of 552 mothers who died, 280 babies (50.7 per cent) were salvaged, either antepartum, intrapartum or postpartum. (2) The incidence of "premature" gestation (135 among the 510) is relatively higher than might be expected. (3) Facts and figures concerning *prenatal care* of any patient in this series are fraught with a certain amount of error due principally to omission of statement or inaccurate estimation of "adequacy" as recorded on available documents.

Johnston[4] studied 23,717 deliveries occurring in Jefferson Davis Hospital during five years, 1957-1961. Forty per cent of the mothers delivered were registered in the prenatal clinic, with adequate prenatal care, while approximately 50 per cent of the mothers delivered had inadequate care or sought *no* professional advice during pregnancy. He found that in all three groups, immature, premature and term pregnancies, the perinatal mortality rate was consistently higher for the non-clinic patient (inadequate prenatal care). Over the five-year period, one woman in five had a hemoglobin of 10 grams or less and among 635 cases of syphilis, due to lack of prenatal care more than half of the patients received no antisyphilitic treatment during their pregnancies.

Some fascinating discoveries related to prenatal care in the Philadelphia area were published by Kane.[5] Data from 144 eastern hospitals were received and processed on computer facilities; 409,766 case records were reviewed covering two years, 1961-1962. Mortality was used as a yardstick rather than diagnostic entities; terminology was the same as that listed in Table 4 (above). Kane found that progressive increase in the number of pregnancies is related to an increase in mortality of the newborn infant, in opposition to older beliefs; previous pregnancy experience is a major factor in infant survival. Quantitative increase in prenatal care, above certain basic levels, does not materially influence the end result for the infant, *except* during the first pregnancy. There is a great need for epidemiologic studies to evaluate the problems of "bad-risk mothers."

Conclusion

1. A survey of records in the Ohio Maternal Mortality Study, relative to "Child Outcome" in the face of maternal death, is presented.

2. Two hundred eighty babies were born *alive* among 643 mothers who died. Fifteen of the live-born survived postmortem cesarean section.

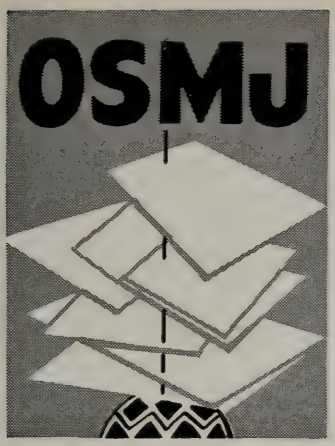
3. The incidence of live births among mothers who received *adequate* prenatal care is markedly higher than among mothers who received inadequate prenatal care, or none at all in this study.

4. This fact alone supports general aims of the Committee on Maternal Health to improve prenatal care among pregnant patients, in order to insure both maternal and fetal health.

"Be good to Mother, before Baby is Born."

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3. Guiding Principles for Obstetric Care. *Ohio State M. J.*, 53: 1328-1329, 1957. (Revised 1963.)
4. Johnston, Robert A., et al.: Prenatal Care. *Southern Med. J.*, 57:399-402 (April) 1964.
5. Kane, Sydney H.: Significance of Prenatal Care. *Obstet. & Gynec.*, 24:66-72 (July) 1964.



NEWS AND Organization Section

Utilization Review Under Medicare ...

Under Conditions for Participation, Hospital Approved by the Joint Commission Must also Meet Utilization Review Criteria

IN ORDER to participate as a hospital under the Medicare law, an institution currently accredited by the Joint Commission on Accreditation of Hospitals will be deemed to meet all of the conditions of participation, except the requirement for utilization review and, in the case of tuberculosis and psychiatric hospitals, the additional staffing and medical records requirements considered necessary for the provision of intensive care. Consequently, a JCAH-approved general hospital will be able to establish eligibility to participate by furnishing adequate evidence that it has an effective utilization review plan.

For hospitals which are not accredited, the conditions of participation are modeled after, and are no higher than, the requirements for accreditation of the JCAH. The JCAH and its sponsors, the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association, have for many years been engaged in a program directed toward the attainment of hospital care meeting professional standards.

UTILIZATION REVIEW PLAN

As a condition of participation the hospital is required to have in effect a plan for utilization review which applies at least to the services furnished by the hospital to inpatients who are entitled to benefits under the law. An acceptable utilization review plan provides for: (1) the review, on a sample or other basis, of admissions, duration of stays, and professional services furnished; and (2) review of each case of continuous extended duration.

Introduction

There are many types of plans which can fulfill the requirements of the law. Hospitals wishing to establish their eligibility to participate should submit a written description of their utilization review plan and a certification that it is currently in effect or that it will be in effect on July 1, 1966. Ordinarily this will constitute sufficient evidence to support a finding that the utilization review plan of the hospital is or is not in conformity with the statutory requirements. Intermediaries will be relied upon heavily to participate with the medical profession and the hospital administrative staff in long-run measures to assure that utilization review operates effectively.

The review plan of a hospital should have as its overall objective the maintenance of high quality patient care, and an increase in effective utilization of hospital services to be achieved through an educational approach involving study of patterns of care, and the encouragement of appropriate utilization. It is contemplated that a review of the medical necessity of admissions and durations of stay, for example, would take into account alternative use and availability of out-of-hospital facilities and services. The review of professional services furnished might include study of such conditions as overuse or underuse of services, logical substantiation of diagnoses, proper use of consultation, and whether required diagnostic workup and treatment are initiated and carried out promptly. Review of lengths of stay might consider not only medical necessity, but the effect that hospital staffing may have on duration of stay, whether assistance is available to the physician in arranging for discharge planning, and the availability of out-of-hospital facilities and services which will assure continuity of care.

Costs incurred in connection with the implementation of the utilization review plan are includable in reasonable costs and are reimbursable to the hospital to the extent that such costs relate to health insurance program beneficiaries. For example, costs may in-

clude expenses incurred for the purchase of data from organizations outside the hospital which compile statistics, profiles, and study results on utilization of hospital facilities and services.

Standard A

The operation of the utilization review plan is a responsibility of the medical profession. The plan in the hospital has the approval of the medical staff as well as that of the governing body.

Standard B

The hospital has a currently applicable, written description of its utilization review plan. Such description includes:

- The organization and composition of the committee(s) which will be responsible for the utilization review function;
- Frequency of meetings;
- The type of records to be kept;
- The method to be used in selecting cases on a sample or other basis;
- The definition of what constitutes the period or periods of extended duration;
- The relationship of the utilization review plan to claims administration by a third party;
- Arrangements for committee reports and their dissemination;
- Responsibilities of the hospital's administrative staff.

Standard C

The utilization review function is conducted by one or a combination of the following:

- By a staff committee or committees of the hospital, each of which is composed of two or more physicians, with or without the inclusion of other professional personnel; or
- By a committee(s) or group(s) outside the hospital composed as above which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality; or
- Where a committee(s) or group(s) as described in the first or second paragraph of this standard has not been established to carry out all the utilization review functions prescribed by the Act, by a committee(s) or group(s) composed as in the first paragraph above, and sponsored and organized in such manner as approved by the Secretary of Health, Education, and Welfare.

Factor 1. The medical care appraisal and educational aspects of review on a sample or other basis, and the review of long-stay cases need not be done by the same committee or group.

Factor 2. Existing staff committees may assume the review responsibility stipulated in the plan. In smaller hospitals, all of these functions may be carried out by a committee of the whole or a medical care appraisal committee.

Factor 3. The committee(s) is broadly representative of the medical staff and at least one member does not have a direct financial interest in the hospital.

The accompanying article is presented by *The Journal* as factual information, without editorial comment, in the interest of keeping physicians abreast of regulations under the Medicare Law. The introductory paragraphs are excerpted from the pamphlet "Conditions of Participation for Hospitals," issued by the U. S. Department of Health Education, and Welfare, Social Security Administration. The standards under "Utilization Review Plan" are quoted bodily from the same pamphlet.

Standard D

Reviews are made, on a sample or other basis, of admissions, duration of stays, and professional services furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such reviews emphasize identification and analysis of patterns of patient care in order to maintain consistent high quality. The review is accomplished by considering data obtained by any one or any combination of the following:

- By use of services and facilities of external organizations which compile statistics, design profiles, and produce other comparative data; or
- By cooperative endeavor with the fiscal intermediary(ies) in the locality; or
- By internal studies of medical records.

Factor 1. Reviews of cases, based on diagnostic categories, include diagnoses of special relevance to the aged group.

Factor 2. Some review functions are carried out on a continuing basis.

Factor 3. Reviews include a sample of recertifications of medical necessity, as made for purposes of the Health Insurance for the Aged Program.

Standard E

Reviews are made of each beneficiary case of continuous extended duration. The hospital utilization review plan specifies the number of continuous days of hospital stay following which a review is made to determine whether further inpatient hospital services are medically necessary. The plan may specify a different number of days for different classes of cases. Reviews for such

purpose are made no later than the seventh day following the last day of the period of extended duration specified in the plan. No physician has review responsibility for any extended stay cases in which he was professionally involved. If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, and considering the availability and appropriateness of out-of-hospital facilities and services, that further inpatient stay is not medically necessary, there is notification in writing within 48 hours to the institution, the attending physician and the patient or his representative.

Factor 1. Because there are significant divergences in opinion among individual physicians in respect to evaluation of medical necessity for inpatient hospital services, the judgment of the attending physician in an extended stay case is given great weight, and is not rejected except under unusual circumstances.

Standard F

Records are kept of the activities of the committee; and reports are regularly made by the committee to the executive committee of the medical staff and relevant information and recommendations are reported through usual channels to the entire medical staff and the governing body of the hospital.

Factor 1. The hospital administration studies and acts upon administrative recommendations made by the committee.

Factor 2. A summary of the number and types of cases reviewed, and the findings, are part of the records.

Factor 3. Minutes of each committee meeting are maintained.

Factor 4. Committee action in extended stay cases is recorded, with cases identified only by hospital case number.

Standard G

The committee(s) having responsibility for utilization review functions have the support and assistance of the hospital's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, and promoting the most efficient use of available health services and facilities.

Factor 1. With respect to each of these activities, an individual or department is designated as being responsible for the particular service.

Factor 2. In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for post-hospital care is initiated as promptly as possible, either by hospital staff, or by arrangement with other agencies. For this purpose, the hospital makes available to the attending physician current information on resources available for continued out-of-hospital care of patients and arranges for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

Written Prescription Required For Class A Narcotic Drugs

Numerous inquiries have been made by physicians as to the law in regard to telephone prescriptions for narcotic drugs. The following communication is the text of a letter addressed to a physician by Rupert Salisbury, Ph. D., executive secretary of the State Board of Pharmacy of Ohio, and explains the law on this subject:

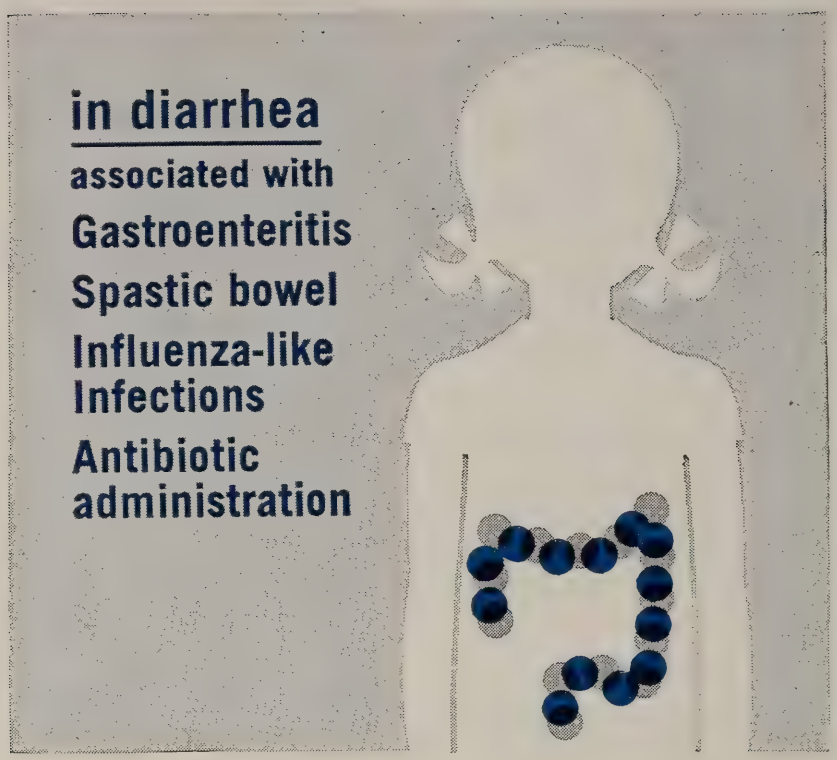
"I have been asked by a pharmacist to explain to you the Narcotic Laws, both Federal and State under which you and the pharmacists in this state must operate. This is with specific reference to Class A narcotic drugs. Such drugs require an original written and signed prescription to be in the receipt of the pharmacist prior to delivery of such drugs.

"The operative section of the law here is Section 151.397 of the Federal Narcotic regulations. This has to do with telephone orders and it states '(a) where written prescriptions signed by the practitioner are required, the furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether signed prescriptions covering such orders are subsequently received or not, but in an emergency, a druggist may deliver or have delivered through his responsible employee or agent, narcotics pursuant to a telephone order, provided a properly prepared signed prescription is supplied before delivery is made which shall be filed by the druggist as required by law.'

"This section is quite clear and in the event that you wish a Class A narcotic dispensed to one of your patients, the pharmacist must be furnished with a signed original prescription prior to such delivery. Such drugs as Demerol, morphine, alone or in combination, constitute Class A narcotics.

"Codeine when in admixture with other drugs such that the narcotic effect is masked by the therapeutic effect of the other drugs, falls into the Class B narcotic category and here an oral prescription over a telephone is sufficient and no written prescription is required. However, this holds true only for codeine in admixture, codeine alone, in any strength, is a Class A narcotic drug.

"Should you have any questions about these laws and their interpretation, the Board of Pharmacy would be most happy to answer them."



normal activity...

promptly...



In children with diarrhea prompt symptomatic control is usually urgently indicated to relieve cramping and to prevent dehydration.

Lomotil halts precipitous progress through the intestines and controls diarrhea with notable promptness, safety and effectiveness.

Experimental evidence[1] has shown that Lomotil is more efficient in this regard than morphine without the latter's manifest disadvantages. In roentgenographic study[2] Lomotil slowed gastrointestinal propulsion within two hours.

At the same time, by diminishing overstimulation of the intestines, Lomotil relieves the abdominal cramps and discomfort so distressing to youngsters.

Lomotil gets children off toast and tea and back to normal diets and normal activity with gratifying celerity.

with LOMOTIL® liquid/tablets

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: may be habit forming)
atropine sulfate .....0.025 mg.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial *daily dosages,* given in divided doses, until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyryl-pyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. *9*:381-400 (June) 1957.

2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. *21*:674-680 (Sept.-Oct.) 1958.

SEARLE

Research in the Service of Medicine

Medicare Intermediaries in Ohio ...

Two Companies Will Administer Payment of Physicians' Bills in This State Under Part B of the Medicare Law

AMONG 48 organizations in the health insurance field named to serve as contractors under Part B of the Medicare Law, two have been designated in Ohio.

Medical Mutual of Cleveland, Inc., is being offered the contract as intermediary for the counties of Ashtabula, Cuyahoga, Geauga, Lake, and Lorain, according to information issued from the Social Security Administration in mid-February.

Nationwide Mutual Insurance Company, with headquarters in Columbus, is being offered the contract for the other counties in the state.

Among the 48 organizations selected are 32 Blue Shield plans, 15 insurance companies, and one independent health insurer. The selected Blue Shield plans will serve 59 per cent of the Nation's Medicare beneficiaries, according to the Social Security Administration; the insurance companies, 38 per cent; and the independent insurer, 1 per cent.

The contractors will receive and pay physicians' bills of older people signed up for the voluntary medical insurance, or Part B of the Medicare Law, under one-year contracts, subject to renewal upon satisfactory performance. Selection of contractors is tentative, subject to agreement as to contract conditions between the individual organizations and the government.

In making these announcements, Robert M. Ball, Commissioner of Social Security, included the following information in his statement:

"The medicare beneficiaries who are members of certain group practice prepayment plans will normally not be served by the area contractor, but by their own plan under special contractual arrangements with the Government. Plans like the Kaiser Foundation Health Plan on the West Coast, Health Insurance Plan of New York, Group Health Association in Washington, D. C.; Group Health Cooperative of Puget Sound in the State of Washington and the Community Health Association of Detroit will fall in this category.

Possible State Agencies

"Where a State enters into an agreement with the Secretary to pay the supplementary medical insurance program premiums on behalf of its aged welfare recipients, the agreement may provide for a designated State agency to serve as a contractor, but only on behalf of its welfare recipients. In that case, the State agency, rather than the area contractor, will serve these beneficiaries. A number of State welfare agencies have indicated that they may want this arrangement.

"Under their contracts with the Government, the individual contractor's primary responsibility will be to pay the reasonable charges for physician and other health services. In determining reasonable charges the contractors will consider the usual and customary charges made by physicians, as well as the prevailing rates in the area for similar services.

"In paying for physicians' services, the contractor must assure that the charges it pays are no higher for medicare patients than for comparable services and under comparable circumstances for its own policyholders or subscribers.

Safeguards

"Contractors will also be concerned with safeguards against unnecessary utilization of covered services and will be required to maintain such records and furnish such information as the Government finds necessary.

"All organizations were evaluated carefully for their ability to maintain good professional relations with physicians, medical societies, and other professional groups. **Under terms of its contract, a contractor will be required to work closely with medical societies and their medical review committees in the area in which it operates to carry out its responsibility** for determining the rates and amounts of payments to physicians and for providing safeguards against unnecessary or improper utilization of services. It will also work closely with other professional groups whose services are covered under the program."

Diagnostic Radiology

On Saturday and Sunday, April 16 and 17, Dr. Edward B. Singleton, director of radiology, St. Luke's and Texas Children's Hospital, Houston, Texas, will deliver the eighteenth annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati College of Medicine. Radiologists desiring to attend are requested to write for further details to Dr. Benjamin Felson, Department of Radiology, Cincinnati General Hospital.

Preview of Practice . . .

Medical Students of Two Ohio Schools Receive Pointers On the Practical Side of Practice as Guests of the OSMA

THE OSMA Committee on Rural Health presented its annual program, "When You Begin Practice," at the Ohio State University and the University of Cincinnati on February 5 and 6.

This special series of talks for junior medical students and their wives or girl friends was greeted at both universities with much enthusiasm, both in numbers and interest.

The programs consisted of an afternoon of practical pointers on the economical, legal and family aspects of setting up practice, some sound ideas on the "art" of medicine and an indication of what the future practice might be like under some of the existing governmental programs.

The afternoon programs were followed with social hours which permitted members of the Committee on Rural Health and the speakers to discuss, informally, many questions raised by the students.

Following the dinners, the wives and girl friends were given a general idea what it is like to be a doctor's wife. The program concluded with talks which pointed out responsibilities of the physician to his community and to his medical society.

A fourth speaker at the OSU program was Assistant Dean of the Medical College, Dr. J. Hutchison Williams.

This series of special talks, sponsored by the Committee on Rural Health in cooperation with the Colleges of Medicine and the campus chapters of the Student American Medical Association, is primarily designed to acquaint junior medical students with the practice of medicine in smaller cities and towns and in rural areas.

This year's program for the Ohio State University students marked the 15th time these lectures have been held at this school. This year's was the 14th lecture series program conducted for the Cincinnati medical students.

The Ohio State Medical Association, in recognizing the importance of the Student AMA, presented checks of $100, each, to the local chapters of this organization.

This stipend is designated to be used to help defray some of the expenses of a representative from each chapter to attend the national meeting of the Student AMA.

Hugh M. MacDonald, president of OSU chapter, and John W. Robinson, president of the Cincinnati chapter, received the checks on behalf of their organizations.

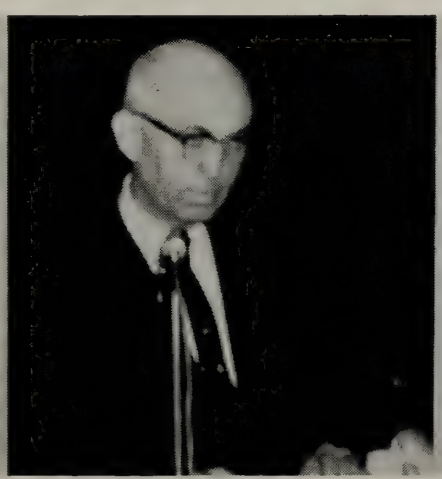
Richard L. Fulton, M. D., Columbus, Tenth District Councilor, presided at the OSU program and Robert E. Howard, M. D., Cincinnati, First District Councilor, presided at Cincinnati.

The program and speakers were as follows: "The Family Physician: His Practice," by Victor R. Frederick, M. D., Urbana; "The Economics of Medical Practice," by Charles H. McMullen, M. D., Loudonville, (at OSU), by John R. Polsley, M. D., North Lewisburg, (at U. of C.); "The Art of Medicine," by Harold C. Smith, M. D., Van Wert; "Medicare and the Future Practice of Medicine," by Jasper M. Hedges, M. D., Circleville.

"The Physician's Wife," by Mrs. Victor R. Frederick, Urbana; "The Physician and His Community," by Robert E. Reiheld, M. D., Orrville; and "The Physician and His Medical Society," presented by Henry A. Crawford, M. D., Cleveland, president of OSMA.



Dr. Reiheld



Dr. Polsley



Dr. Smith



Dr. Crawford

Speakers in the "When You Begin Practice" Series

(See also facing page)



Mrs. Frederick



Dr. Howard



Dr. Hedges



Dr. Frederick



Dr. Fulton



Dr. McMullen



Medical student group at the Cincinnati meeting.

'CARE of the PATIENT: 1966'

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MAY 24 through MAY 28



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See THE NEW LOOK at...

YOUR OHIO STATE MEDICAL ASSOCIATION

ANNUAL MEETING



COMPLETE..DETAILED PROGRAM

APRIL ISSUE

OHIO STATE MEDICAL JOURNAL

State Medical Board Resolution Pays Tribute to Dr. Platter

The following resolution was forwarded to *The Journal* by Dr. Donald F. Bowers, Columbus, interim secretary of the State Medical Board:

RESOLUTION

"WHEREAS, Herbert Morris Platter, M. D., has faithfully and devotedly performed his duties as Secretary of the State Medical Board of Ohio for the past forty-eight years, and

"WHEREAS, Dr. Platter has been a physician for seventy-three years, during which he has served not only the State Medical Board and the State of Ohio, but also his patients, and has further been recognized locally and nationally for his services and pioneer efforts in postgraduate medical education, public health measures, organization of the Federation of State Medical Boards, and participation in the original Medical Practice Act for the State of Ohio, and

"WHEREAS, The State Medical Board of Ohio is aware of the exceptionally long and faithful service, devotion, dedication, and interest to the Board, to the State of Ohio, to the nation, as well as to the medical profession, and

"WHEREAS, Dr. Platter has now signified his desire to be relieved from his historic duties, and

"WHEREAS, The State Medical Board of Ohio desires to express its gratitude to Dr. Platter for his outstanding and remarkable contributions,

"NOW, THEREFORE BE IT RESOLVED by the State Medical Board of Ohio that the Board on behalf of itself and the State of Ohio extend its appreciation and sincere gratitude to Dr. Platter for his forty-eight years of faithful service to the Board, and for his seventy-three years of continuous service to the public, and

"BE IT FURTHER RESOLVED, That copies of this Resolution be made available to the Governor of the State of Ohio, the Ohio State University, the American Medical Association, The Ohio State Medical Association, and the Federation of State Medical Boards of the United States.

"Columbus, Ohio, this 17th day of December, 1965."

The resolution bears the signature of members of the Board and is stamped with the Board's official Seal.

Dr. Platter, who retired at the age of 96, December 31, is making his residence in the Lutheran Senior City, Columbus.

The Illinois State Medical Society is inviting physicians from other states to attend its Spring conference on narcotic addiction to be held March 24-25 at the Sherman House in Chicago. Persons wishing details may write the society at 360 N. Michigan Avenue, Chicago, Illinois 60601.

New Provisions in OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to new provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cleveland, May 24 - 28.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 28.

The revised section in the OSMA Bylaws pertaining to the procedure reads as follows:

Section 1 (a). Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates, provided however that only those candidates may be nominated whose names have been filed with the Executive Secretary at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon filing of such candidate's name, the Executive Secretary, if such candidate is eligible for election, shall prepare and transmit this information to each member of the House of Delegates. No candidate may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the Delegates present at the opening session of such meeting. The Executive Secretary shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all eligible candidates meeting the requirements of filing and transmittal.

OMPAC Membership Now 2,228...

Substantial Gain Shown in Past Month; No Members Recorded In 20 Counties; Aims and Potentials of OMPAC Summarized

PHYSICIANS from 68 counties had affiliated with the Ohio Medical Political Action Committee up to February 17. Membership on that date totaled 2,228, a gain of approximately 1,000 members in the past month.

OMPAC officials credit this good showing to the excellent work being done by County Medical Society secretaries in most counties, in collecting OMPAC dues at the same time Medical Society dues are being collected. Some county groups apparently are not following this procedure which was recommended by The Council of the Ohio State Medical Association. Those are the counties which show few, if any, OMPAC memberships.

May Join Direct

Individual physicians who may reside in a county where the County Medical Society secretary is not collecting OMPAC dues may join direct by sending their $25.00 membership dues to OMPAC, P. O. Box 5617, Columbus, Ohio 43221.

Membership cards have been mailed to approximately 1,200 members. Membership cards will be mailed within the next few weeks to the balance of the membership and, periodically, to additional members as dues are received.

A contribution of $10.00 per member is made by OMPAC to the American Medical Political Action Committee, Chicago. This qualifies each Ohio member for AMPAC membership. Membership cards in AMPAC are mailed from Chicago.

OMPAC's Aims and Potentials

OMPAC has the following primary aims and potentials which need financial backing in order to get off the ground:

- Become the spearhead of the fight in Ohio to help in the nationwide battle to keep medicine's friends in the Congress and retire its opponents.
- Become the strong right arm of the medical profession of Ohio in political activities. (Medical societies can't engage in political activities because of legal barriers.)
- Be of assistance to the medical profession of Ohio in its legislative battles . . . state and national.
- Provide financial assistance to a greater number of Ohio candidates for public office.
- Help in financing educational campaigns by the medical profession to acquaint the public with the medical profession's views on social, economic and legislation questions affecting public health and the practice of medicine.
- Assist Ohio physicians, and others, locally and on a regional basis to organize effective political action groups.
- Organize public education campaigns, to promote the improvement of government . . . to encourage and stimulate physicians . . . citizens generally . . . to take a more active part in governmental affairs . . . join with other substantial groups in such activities.
- Issue newsletters and informative material periodically to Ohio physicians in order to keep them acquainted and up-to-date with political happenings and trends throughout the nation.
- Help to organize and finance regional and state conferences of Ohio physicians and their wives, and others . . . workshops . . . where political, legislative and governmental subjects and information can be discussed and plans for action developed.
- Help to bring about increased liaison with other Ohio professions, business and industrial groups, etc., in order to develop concerted action on political and legislative matters.
- Assist the medical profession of Ohio in its pre-election activities.
- Cooperate with AMPAC in helping to elect qualified candidates in other states and support AMPAC's nationwide campaign for better government.

Membership by Counties

Following is a breakdown of OMPAC membership by counties as of February 17:

Adams 1	Fairfield 1	Licking 1	Portage 26
Allen 68	Fayette 12	Logan 0	Preble 0
Ashland 6	Franklin 215	Lorain 55	Putnam 0
Ashtabula 14	Fulton 3	Lucas 4	Richland 1
Athens 12	Gallia 2	Madison 2	Ross 21
Auglaize 2	Geauga 10	Mahoning 85	Sandusky 11
Belmont 18	Greene 19	Marion 11	Scioto 33
Brown 6	Guernsey 3	Medina 17	Seneca 20
Butler 66	Hamilton 382	Meigs 0	Shelby 15
Carroll 6	Hancock 3	Mercer 2	Stark 164
Champaign 0	Hardin 0	Miami 37	Summit 0
Clark 54	Harrison 6	Monroe 0	Trumbull 52
Clermont 4	Henry 7	Montgomery 217	Tuscarawas 26
Clinton 5	Highland 0	Morgan 0	Union 2
Columbiana 0	Hocking 1	Morrow 2	Van Wert 0
Coshocton 0	Holmes 6	Muskingum 25	Vinton 0
Crawford 35	Huron 13	Noble 1	Warren 0
Cuyahoga 253	Jackson 0	Ottawa 6	Washington 0
Darke 7	Jefferson 2	Paulding 1	Wayne 27
Defiance 4	Knox 25	Perry 3	Williams 0
Delaware 7	Lake 57	Pickaway 6	Wood 2
Erie 0	Lawrence 15	Pike 0	Wyandot 3
			Total 2228

Weil Memorial Lectureship Scheduled in Akron

The third annual Alven M. Weil Memorial Lectureship has been scheduled for Akron, on Wednesday, March 9. The program will begin at 4:00 p. m. in the Akron City Club with a three-man panel presentation on "Dysfunctional Labor." The following panelists will participate:

Dr. D. Anthony D'Esopo, professor emeritus, Columbia University College of Physicians and Surgeons, and consultant obstetrician and gynecologist, Presbyterian Hospital.

Dr. Charles Henning Hendricks, professor of obstetrics and gynecology at Western Reserve University School of Medicine.

Dr. Louis M. Hellman, professor and chairman of the Department of Obstetrics and Gynecology, State University of New York, Downstate Medical Center.

Cocktails and dinner will follow the presentation. Reservations may be made by writing: Summit County Medical Service Bureau, Inc.; Attn., Akron Obstetrical and Gynecological Society, 211 Second National Building, Akron 44308.

After dinner speaker will be Dr. Hellman whose topic will be "The Use of Electronics in Obstetrics and Gynecology."

The Obstetrical and Gynecological group is sponsoring the lectureship under the direction of Richard J. Yoder, M. D., president, and Ronald B. Mitchell, M. D., secretary.

Western Reserve Dental School Tests Self-Teaching Method

Using workbooks, film slides, and school equipment, but without the traditional lecturer to guide them, freshmen students at the Western Reserve University School of Dentistry are teaching themselves. An instructor is available, but only to answer questions.

The workbook and slides, developed in a three-year research project by Henry G. Vanek, D. D. S., assistant professor of operative dentistry, and his associates at the School, were presented to 30 students — half of the second-semester freshman class. The other half is learning this part of the dental course from the usual lecture and laboratory instruction.

All 60 are thereby contributing to a demonstration that is expected to lead to more extensive teacherless instruction at this dental school and elsewhere — an educational trend made necessary by the shortage of instructors and the increasing body of scientific knowledge that must be taught to future dentists in a relatively short time.

Convincing evidence that self-instructed groups can learn the same amount of knowledge and achieve the same grade averages *in less time* than those taught by the usual methods has already been gathered by testing students who tried out the workbook in earlier versions during the past two years, school officials report.

American College of Surgeons Joint Cleveland Meeting

More than 2,500 surgeons and graduate nurses are expected to attend the annual four-day Sectional meeting of the American College of Surgeons in Cleveland, March 14-17. (Refer to January issue of *The Journal,* page 61.)

Purpose of this 12th annual joint meeting for doctors and nurses, which pioneered in Cleveland in 1955, is the exchange of information between medical and nursing services to improve care of the surgical patient.

Registration is open to all doctors of medicine and graduate nurses. Headquarters hotels will be the Sheraton-Cleveland and Statler-Hilton.

"Doctors and nurses from all over Canada and the United States will attend this intensive scientific meeting to learn significant advances in surgery," according to Dr. John H. Davis, associate professor of surgery, Western Reserve University School of Medicine, and chairman of the local advisory committee on arrangements for the doctors' sessions.

"Some 300 doctors and nurses on the program will act as teachers, focusing attention on newer ways of handling surgical procedures and supervising nursing care of patients," Dr. Davis explained.

Dr. Warren Wendell Green, Toledo, president, Ohio Chapter of the College, will be chairman at this Chapter's luncheon on the opening day.

Also on the first day Dr. Howard A. Patterson, New York, president of the College, will preside over sessions at which Dr. Robert M. Zollinger, Columbus, a regent of the College, will moderate a panel on breast cancer. A panel on evaluation of the poor risk patient for operation will follow, moderated by Dr. William D. Holden, Cleveland.

The opening day's surgery program will also include a report on what's new in burns, by Dr. Bruce G. MacMillan, Cincinnati. In the specialty of orthopedic surgery Dr. Walter A. Hoyt, Jr., Akron, will moderate a panel on injuries of the spine, and Dr. Charles H. Herndon, Cleveland, one on bunion treatment.

In ear-nose-throat discussions Dr. Hollie E. McHugh, Montreal, and Dr. William J. Loeb, Cleveland, will preside. In plastic surgery meetings Monday, Dr. Clifford L. Kiehn and Darrel T. Shaw, Cleveland, will guide the program, and in urology Dr. William E. Forsythe, Jr., Cleveland, and Dr. Justin E. Cordonnier, St. Louis.

"My Experiences with Project Hope in Africa" is the title of an address by Dr. Harvey J. Mendelsohn, Cleveland, guest speaker at the nurses' luncheon March 16.

Deadline for Submission of Resolutions to Columbus Office of the Association Is March 25

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1966 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Tuesday evening, May 24, at the Sheraton-Cleveland Hotel, Cleveland.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 25. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting intructions from their County Medical Societies.

OSU Medical College Gets Grant For Basic Science Building

The Ohio State University College of Medicine moved a step closer to its goal of admitting 200 students per entering class with recent awarding of an extensive construction grant.

The College has been awarded a construction grant of $6,013,546 by the U. S. Public Health Service to assist in construction of a new basic science building. The project will cost approximately $12 million for a five-story building. Balance of the construction funds will come from the 1963 bond issue which was passed by Ohio voters.

Dr. Richard L. Meiling, dean of the College, predicted that when the new basic science building is completed 50 students will be added to the entering class in medicine. Present enrollment in the first year class is 150.

Dr. Meiling said that the first two floors of the new basic science building will provide multi-discipline laboratories for first and second year medical students. Third, fourth and fifth floors will house departmental offices and teaching laboratories for pathology, pharmacology, microbiology, anatomy, physiology, and physiological chemistry.

Plans call for a two-story annexed wing, which will contain two auditorium-type classrooms, each seating 275 persons. Also included in the wing will be administrative offices of the College of Medicine, a student lounge, a staff lounge and closed-circuit television teaching facilities.

The building will be located adjacent to the Medical Center between Ninth and Tenth Avenues in Columbus. Construction is expected to begin late in 1966 with occupancy anticipated in 1968.

Pediatric Lectureship Presented on Neonatal Hyperbilirubinemia

The thirteenth Benjamin Know Rachford Lectureship, presented under direction of the University of Cincinnati College of Medicine, was in the form of a "Symposium on Neonatal Hyperbilirubinemia." The following speakers presented the topic material indicated:

Dr. Rudolf Schmid, professor of medicine, University of Chicago, "Experimental Studies on Bilirubin Metabolism."

Dr. Louis K. Diamond, professor of pediatrics, Harvard University, "Neonatal Hyperbilirubinemia Due to Increased Red Cell Destruction."

Dr. Gerald R. Odell, associate professor of pediatrics, Johns Hopkins University, "Non Hematologic Neonatal Hyperbilirubinemia."

Dr. Benjamin H. Landing, professor of pathology and pediatrics, University of Southern California, "Neonatal Hepatitis."

Obituaries

Ad Astra

C. Lloyd Beatty, M. D., Akron; University of Western Ontario Faculty of Medicine, 1923; aged 67; died January 2; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Beatty's practice in Akron extended over some 28 years. Among affiliations, he was a member of several Masonic bodies. Surviving are two sons, a daughter and a brother.

Sam Crawford Clark, M. D., Cherry Fork; University of Cincinnati College of Medicine, 1915; aged 77; died January 13; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Adams County for more than 50 years, Dr. Clark was active in numerous community affairs. He was a member of the county board of health, a member of the board of directors of the Adams County Hospital, and former county coroner. He served as delegate to a number of National Democractic Conventions and was former mayor of Cherry Fork. Surviving are his widow and a daughter.

Laurence Starr Cutter, M. D., Clemson, S. C.; University of Cincinnati College of Medicine, 1925; aged 68; died January 12. A practicing physician of long standing in Cleveland, Dr. Cutter retired about a year ago and moved to South Carolina. His widow and a daughter survive.

Thomas W. Durbin, M. D., Toledo; University of Michigan Medical School, 1921; aged 71; died January 15; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in Toledo, Dr. Durbin had been retired for some years for health reasons. He is survived by his widow and three daughters.

John Rudolph Finley, M. D., Cleveland; Ohio State University College of Medicine, 1916; aged 74; died January 9; member of the Ohio State Medical Association and the American Medical Association. A former resident of Cleveland, Dr. Finley moved to California for a short time and then returned to Cleveland to resume his practice. His specialty was obstetrics and gynecology. A member of the Episcopal Church and a veteran of World War I, he is survived by his widow, and two sisters.

Justin J. Haberer, M. D., Oakland, Calif.; St. Louis University School of Medicine, 1939; aged 51; died January 4. A former practitioner in Dayton and in New Lebanon, Dr. Haberer held a State appointment in Columbus before he left to practice in California about five years ago. He was a member of several Masonic bodies and a veteran of World War II. Surviving are his widow, a daughter, a son, his parents and three sisters.

Charles H. Leatherman, M. D., Cleveland; Meharry Medical College, 1926; aged 67; died January 19; former member of the Ohio State Medical Association and the American Medical Association; member of the National Medical Association. A general practitioner of long standing in Cleveland, Dr. Leatherman was associated with the YMCA and the AME Church. His widow survives.

Frank Adolph Oldenburg, M. D., Cuyahoga Falls; Marquette University School of Medicine, 1940; aged 51; died December 1; member of the Ohio State Medical Association, the American Medical Association, American Society of Anesthesiology, and the International Anesthesia Research Society. A native of Milwaukee, Wisconsin, Dr. Oldenburg had been a practicing physician in the Summit County area since about 1944.

Joseph O. Porter, Sr., M. D., Cincinnati; University of Virginia School of Medicine, 1921; aged 69; died January 15 in an airplane accident; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Cincinnati, Dr. Porter was a veteran of World War I. He is survived by his widow, three daughters and a son, Dr. Joseph O. Porter, Jr., of Cincinnati; also five sisters and a brother survive.

Wilmer Howell Rogers, M. D., Amsterdam; Tulane University School of Medicine, 1928; aged 59; died January 28; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A general practitioner in the Amsterdam area for about 30 years, Dr. Rogers was former Jefferson County coroner and was mayor of his community at one time. Affiliations included memberships in the Moose Lodge, the Elks Lodge, and the Catholic Church. Surviving are his widow, three daughters, a son, his mother, two sisters, and a brother.

Donald Mason Rothrock, M. D., Youngstown; University of Pennsylvania School of Medicine, 1917; aged 70; died January 28; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A former resident of Pennsylvania, Dr. Rothrock served most of his professional career in Youngstown. He was a veteran of World War I. Affiliations in-

cluded memberships in the Elks Club and the Methodist Church. His widow survives.

Salvatore M. Sancetta, M. D., Cleveland; Western Reserve University School of Medicine, 1941; aged 48; died January 11; member of the Ohio State Medical Association, the American Medical Association, Central Society for Clinical Research, American College of Physicians, and the International Academy of Pathology; diplomate of the American Board of Internal Medicine. A specialist in cardiology, Dr. Sancetta was associated with Metropolitan General Hospital, and was on the faculty of Western Reserve University School of Medicine. Last May he was elected president of the Northeastern Ohio Heart Association. A veteran of World War II, he is survived by his widow, a son, two daughters and a brother.

Robert E. Shapiro, M. D., Syracuse, N. Y.; State University of New York Upstate Medical Center, 1951; aged 47; died January 1. Dr. Shapiro formerly took residency work at Children's Hospital in Columbus.

Frederick Agenstein Smith, M. D., Akron; University of Kansas School of Medicine, 1926; aged 66; died January 25; member of the Ohio State Medical Association, the American Medical Association, American Diabetes Association, and the American Rheumatism Association. A practitioner in Akron since 1927, specializing in internal medicine, Dr. Smith served in the Pacific Theater during World War II. He was a member of the Church of the Latter Day Saints. Survivors include his widow, a daughter, two brothers, and a sister.

Charles O. Reynolds, M. D., St. Petersburg, Fla.; University of Cincinnati College of Medicine, 1912; aged 78; died January 24. A practitioner of long standing in Huntington, W. Va., Dr. Reynolds was well known in Southern Ohio. His widow survives.

Willard A. Van Nest, M. D., New Smyrna Beach, Fla.; Stritch School of Medicine of Loyola University, 1936; aged 63; died January 25. Dr. Van Nest practiced for a short time in Toledo before moving to Florida about 20 years ago, His widow is among survivors.

Cases of infectious hepatitis in 1965 were about 10 per cent below the number reported in 1964, the fourth successive year to show a reduction. Even so, the number of cases reported in 1965 totaled nearly 33,650, compared with the all-time high of nearly 73,000 cases reported in 1961. — *Metropolitan Life.*

Mortality in the United States was at about the same level in 1965 as in the preceding year. The statisticians estimate the national death rate for 1965 to be 9.4 per 1,000 population, the 18th successive year to register a death rate below 10 per 1,000. — *Metropolitan Life.*

Hospital Orderly Wanted by FBI Believed to Be in Ohio

The Federal Bureau of Investigation has reason to believe a fugitive may be employed or seeking employment as a hospital orderly or male aide in Ohio.

He is Richard Dale Bartloff, also known as Richard Elmore Bartloff, Dale Bartloff, and "Richie."

Bartloff is being sought by the FBI for allegedly violating probation on a charge of theft of mail. A bench warrant for his arrest was issued on October 20, 1964, in Detroit, Michigan.

He has had employment in the past as a hospital orderly or male aide. Bartloff is described as male; race, white; born, July 27, 1937, Berrien Springs, Michigan; height, 5'10"; 155 pounds; hair, blonde; eyes, hazel. Scars and marks: mole on left leg, scar on right forefinger, cut scar on palm of right hand, cut scar on right index finger.

Any person having information concerning this individual, is requested to notify the nearest office of the FBI, the telephone number of which may be located on the first page of the telephone directory.

The eighth annual Refresher Course in Diagnostic Roentgenology will be held by the Radiology Department of the University of Cincinnati College of Medicine under the direction of Dr. Benjamin Felson from May 31 through June 4.

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The Readjustment Center
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Phone: (AC 313) 663-5522



Activities of County Societies . . .

First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINATI)

CLINTON

Clinton County Medical Society held its January meeting at Clinton Memorial Hospital Tuesday night (Jan. 25) and heard Dr. William Schubert, director of the clinical research center at Cincinnati Children's Hospital, speak on children's digestive ailments. — *Wilmington News-Journal.*

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

MONTGOMERY

The Montgomery County Medical Society approved a proposed program through which researchers from the Department of Preventive Medicine at Ohio State University College of Medicine will conduct a major study of coronary heart disease in the Dayton area. (Part of the study will be made in the Columbus area.) The team hopes to examine some 10,000 persons in the Dayton area, with a follow-up of selected numbers from this group.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Dr. Richard Bing, professor of medicine at Wayne State University, Detroit, was guest speaker for the January 11 meeting of the Academy of Medicine of Lima and Allen County. His topic was "The Recognition of Coronary Artery Disease."

HARDIN

Dr. H. Curtis Wood, medical field consultant for the Association for Voluntary Sterilization, was guest speaker for the Hardin County Medical Society at its January meeting in Hardin Memorial Hospital, Kenton.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

Among programs presented in Toledo during February was the Postgraduate Lecture Series given at the Academy of Medicine building, on February 17 and 18. Dr. Robert J. Marshall, West Virginia University School of Medicine, discussed the various phases of cardiovascular disease.

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

ASHTABULA

The public press of the area reported a full list of committees of the Ashtabula County Medical Society as presented to the press by Dr. J. Richard Nolan, of Ashtabula, the 1966 president of the Society.

CUYAHOGA

The Academy of Medicine of Cleveland building is a busy place, where numerous meetings are held throughout the month. During February the following meetings were scheduled in the building: Combined meeting of the Cleveland Society of



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Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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Pathologists and the Cleveland Chest Society, Academy of General Practice, Cleveland Rheumatism Society, Cleveland Gastroenterology Club, weekly Psychiatric Courses; weekly Neurology Seminars, Heart Association Scientific Council, Medical Assistants, Cleveland Society of Internal Medicine, and the Cleveland Radiological Society.

The Academy of Medicine of Cleveland is sponsoring a series of broadcasts over Station WGAR in Cleveland on Sunday evenings beginning at 7:00 p. m. During February the following topics were discussed on the dates indicated:

February 6 — "Medicine and the Great Society."
February 13 — "Family Life Education."
February 20 — "Cancer Research."
February 27 — "Cancer Therapy."

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

Installation ceremonies for new officers of the Mahoning County Medical Society were held at the January 28 dinner - dance meeting of the society at the Mural Room, Youngstown. Members of the local dental society and their wives were guests for the occasion.

Dr. F. A. Resch, as incoming president, received the gavel from Dr. John J. McDonough.

Special honors were paid to Dr. W. K. Allsop, who received the 50-Year Button and certificate of the Ohio State Medical Association from Dr. Edwin R. Westbrook, Warren, Councilor of the Sixth District.

SUMMIT

Members of the Summit County Medical Society participated in a program on February 1 at which the topics of discussion were "State University Status?" and "A Medical School for Akron?"

TRUMBULL

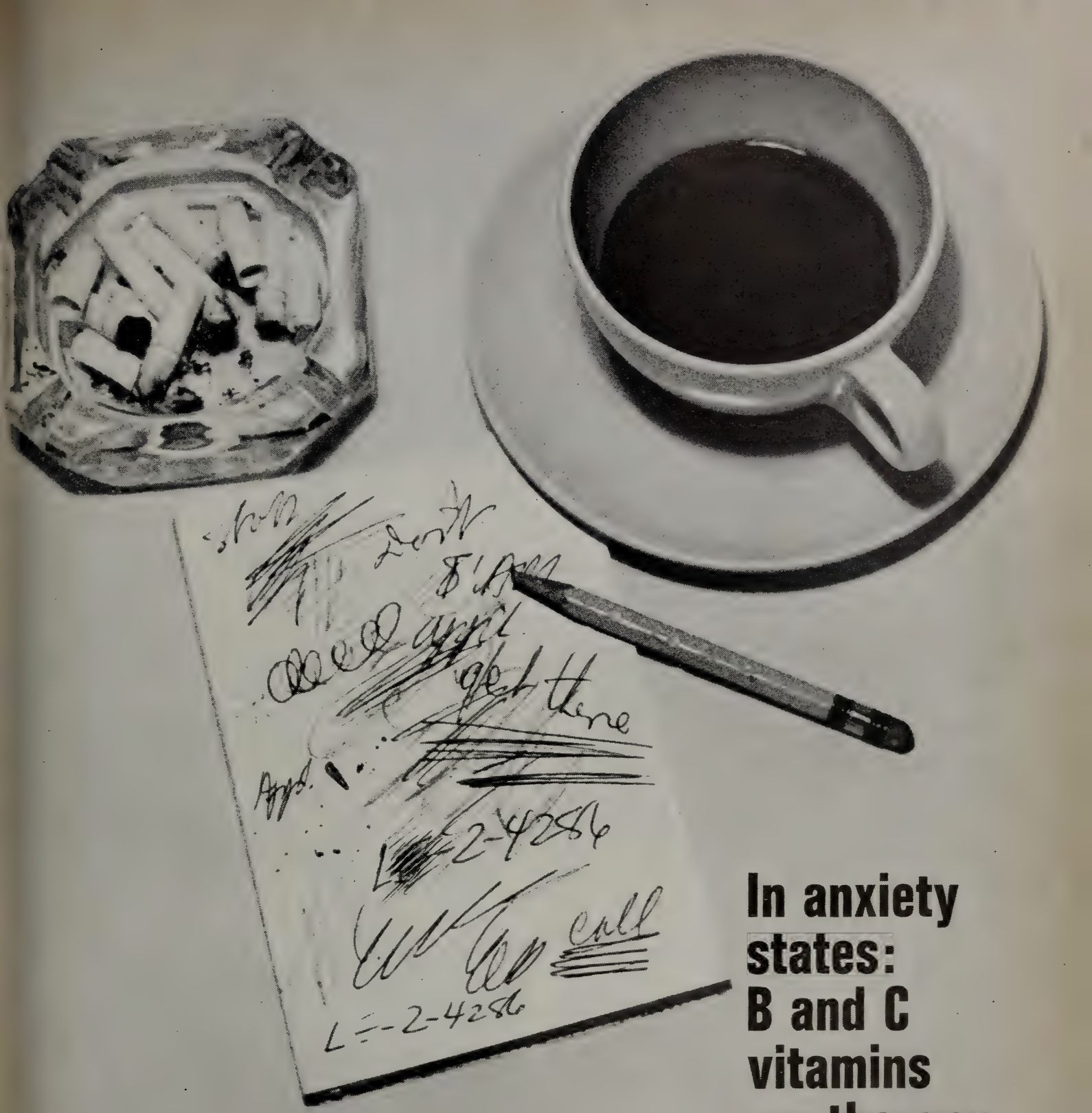
The Trumbull County Medical Society held its first meeting of 1966 recently at the Trumbull Country Club with Dr. John McGreevey, president, presiding.

Several socio-economic problems were discussed and clarified for the group. Dr. Allan Schaffer, president-elect and program chairman, outlined plans for next year.

(This report from the *Warren Tribune Chronicle* was followed by a roster of new officers and committee members.)

The regular meeting of the Trumbull County Medical Society was held on February 16 at the Trumbull County Club, where a social hour, dinner, and program were held. Robert A. Lang, executive secretary of the Academy of Medicine of Cleveland, was the program speaker for a discussion on the new Medicare regulations.





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Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

BELMONT

The Belmont County Medical Society with the Auxiliary met on February 17 at the Holiday Inn for an afternoon program and dinner. Speaker for the occasion was Robert C. Green, staff assistant in the regional bureau of health office at Charlottesville, Virginia. The topic of discussion was "Current Aspects of Medicare."

TUSCARAWAS

Dr. Thomas Meney, director of the radiology service at the Cleveland Clinic, spoke on "The Role of the Kidney in Hypertension," at the January 12 meeting of the Tuscarawas County Medical Society.

Ray Waggoner, president of the Tuscarawas County Pharmaceutical Association, also spoke at the meeting, where he outlined areas of cooperation between pharmacists and physicians.

Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, M. D., ZANESVILLE)

WASHINGTON

Dr. Mary Whitacre Owen was elected president of Washington County Medical Society at a meeting last night (Jan. 12) in Lafayette Motor Hotel, becoming the first woman physician to be so honored in the county.

Named to serve with her were Dr. A. M. Jones Jr., vice-president, and Dr. George E. Huston, secretary-treasurer.

A clinical presentation accompanied by slides was presented for the program by Dr. Charles W. Thacker, pathologist at Camden-Clark Hospital in Parkersburg. — *Marietta Daily Times.*

Ninth District

(COUNCILOR: GEORGE NEWTON SPEARS, IRONTON)

JACKSON

The Jackson County Medical Society held its annual meeting and ladies' night dinner in Jackson. The Society went on record as endorsing the proposed Jackson General Hospital, for which the people of Jackson voted a $470,000 bond issue at last November's election.

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

A combined specialty society meeting and meeting of the Academy of Medicine of Columbus and Franklin County was held in the Neil House Hotel, Columbus, on February 15. A social hour and dinner preceded the programs.

The Neuropsychiatric Society of Central Ohio presented Dr. Jack F. Wilder, New York City, who discussed "Psychosocial Rehabilitation Programs in Community Mental Health Centers."

For the Academy meeting, a panel discussion was conducted on the topic, "Blood Banking, or, Why Do We Have Trouble Getting Enough Blood in Central Ohio?" Dr. Wesley L. Furste, was moderator, with Dr. Ralph D. Lausa as co-moderator. Participating were Dr. Brooks H. Hurd, Dr. Colin R. Macpherson; also Alfred L. Baron, executive director of the Central Ohio American Red Cross unit, and Dr. Sergio L. Cruz, medical director of the Central Ohio American Red Cross Blood Program.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

LORAIN

A total attendance of 71 marked the February 8 meeting of Lorain County Medical Society, in a joint meeting with members of the Lorain County Bar Association. President Joseph A. Cicerrella, M. D., introduced the featured speaker, The Honorable James L. McCrystal, Common Pleas Judge of Erie County. Active in community affairs, Judge McCrystal has served on the Board of Providence Hospital, Sandusky, for 15 years.

His topic encompassed several areas in the liaison between the two professions and their mutual responsibility towards the patient-client.

During the business session, Richard C. Zbornik, M. D., Lorain, was elected into Active Membership in the Society.

Members' attention was directed to communications from Ohio State Medical Association concerning the deadline for submission of Resolutions, and nominations for President-Elect to House of Delegates.

A. Clair Siddall, M. D., chairman of the Cancer Committee, reported on his Committee's activities. A Resolution relative to Reimbursement under Medicare for Services of Hospital-Based Physicians was read and unamimously approved for transmittal to Ohio State Medical Association.

AMA Environmental Health Program, Chicago, April 4 and 5

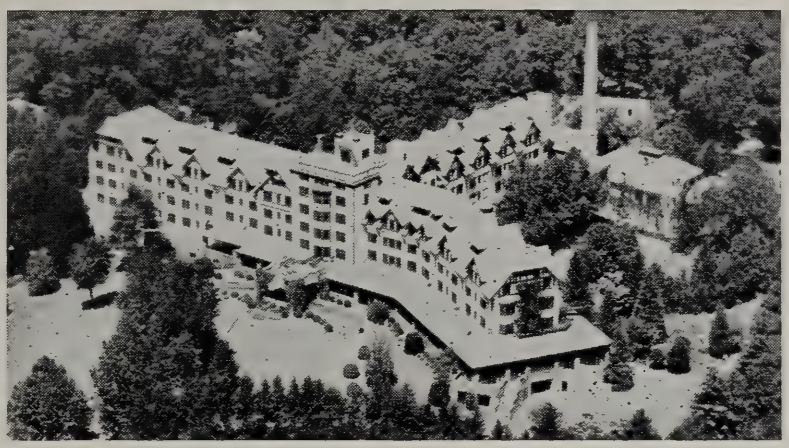
"Impact of Environment on Accidental Injuries and Fatalities" has been announced as the theme for the Third AMA Congress on Environmental Health Problems, scheduled at the Drake Hotel, Chicago, Monday and Tuesday, April 4 and 5.

This program is acceptable for 12 accredited hours by the American Academy of General Practice. A fee of $10 is payable at time of registration, but advance registration may be made with the Department of Environmental Health of the AMA. Persons planning to attend should make their own hotel reservations.

Women are going into medicine in increasing numbers, according to a report of the Association of American Medical Colleges. Women accounted for 7.3 per cent of medical school graduates in 1965, compared to 4.5 per cent in 1930. Women students accounted for 9.1 per cent of those accepted for medical schools for the 1964-1965 academic year.

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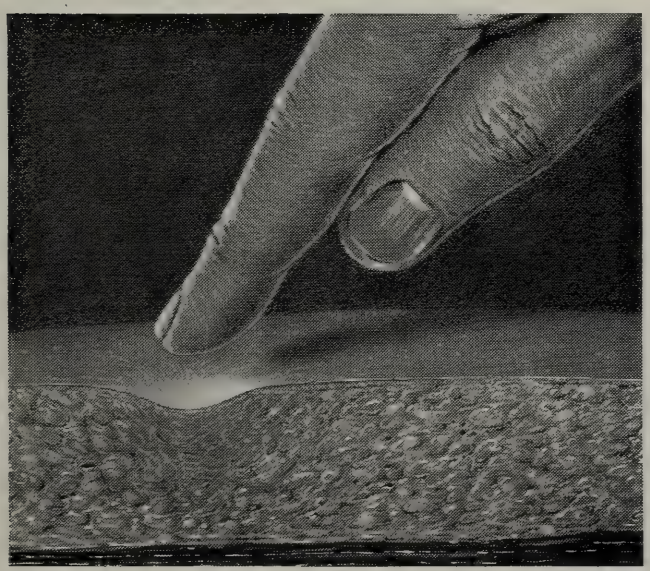
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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Publicity Committee
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WHAT I am about to relate happened more than ten years ago. But the incident is warm and touching and can easily stand the retelling. The doctor's wife had had a bad day. One of the children had been ill and the other two had been into every possible form of devilment. The telephone had jangled constantly. (The doctor's office adjoined his home and the office nurse was away ill.) Even the weather had added to the harassment of the day. The rain had plummeted down stormily for hours and the roof over the children's playroom in the back had sprung a leak. Worst of all, the doctor had been called out on an emergency and there had been a never-ending (or so it seemed) line of petulant patients seeking him out. And angry because he wasn't there at the office to keep his appointments. One had argued unpleasantly about his bill.

Now it was nearing dinner time and the frustrated woman of the house was trying to get a meal together. She had had it, she told herself. This business of being a doctor's wife was for the birds. She had to share him with everyone else — and she seemed to come up inevitably with the short end of the stick. Did anyone ever appreciate the doctor or his family or have the slightest awareness of **their** problems? she asked herself bitterly. No, the doctor's wife decided, nobody did. Nobody cared.

And then came the knock at the door. It was dusk outside. The little old lady who stood on the porch, hat askew, held something very carefully in her hands. It was a birthday cake, she explained, for doctor.

The very tired doctor's wife, annoyance riding her voice, explained that it was not her husband's birthday. "Oh, I know that" the little old lady said breathlessly. "It's **my** birthday. But it really belongs to doctor. I wouldn't be having a birthday today if it weren't for him. He saved my life last winter. He never failed me when I needed him. Not even the night of the blizzard." She smiled a warm, beautiful smile. "Please give him this very special cake with all my love." She paused — and then added softly: "You are a very lucky woman to have the privilege of being his wife."

A thoroughly ashamed-of-herself young woman carefully took hold of the cake plate and its precious cargo. I **am** a very lucky woman, she thought contritely. She murmured "doctor's wife" and she felt herself grow tall. (Corny? I don't think so. I know that doctor's wife and I know what one grateful little old lady did for her.)

Around the State

Since 1951, the **Allen County** auxiliary has "mothered" the Best Years Club at the YWCA. Meeting once a month, this group of Lima women, past 65 years of age, enjoy fellowship, knitting, sewing, quilting and crafts plus a dessert luncheon served by auxiliary members. Twice each year, a covered-dish dinner for these women is on the auxiliary agenda, with the doctors' wives furnishing the food. Mrs. David Barr, Allen County's AMA-ERF chairman, was the recipient recently of two honors. She was first prize winner in Lima's city flag contest and second prize winner in the city's motto contest. Her winning flag design was in red, white and blue with the borders in red and blue "L's." A dozen yellow stars at the top of the crest represented the 12 original townships of the county. The center



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was symbolic of the oil boom and industrial rise of the city. Her second-place motto was "Growth, Education and Opportunity for All."

The **Butler County** group had a busy January meeting. The women packed drug samples for World Medical Relief at the home of Mrs. Clifford Fening, assisted by Girl Scout Troop 136. Mrs. Louis Skimming, local international health chairman, reported that nine barrels of drugs were packed. A week earlier, the members had observed International Health Day with an all-out campaign to collect as many drug samples as possible.

The **Knox County** auxiliary held its January meeting at the home of Mrs. Robert Sooy. Mrs. Clinton Trott was assistant hostess. Mrs. James Kennedy, vice-president, presided at the business session. Named delegate to the state convention in May was Mrs. William Perle, with Mrs. Richard Smythe designated as alternate. Plans were completed at that meeting for the party that was given later in the month for the Golden Age Club. Mrs. Julius Shamansky headed that committee. Films on Health Careers are being shown at the junior and senior high schools. Following each showing, mimeographed answers to the many student questions asked are distributed by the auxiliary. The Knox County members realized a profit of $200 from their sale of Christmas cards for AMA-ERF. Mrs. Sooy was chairman of that project. Medical samples, journals and

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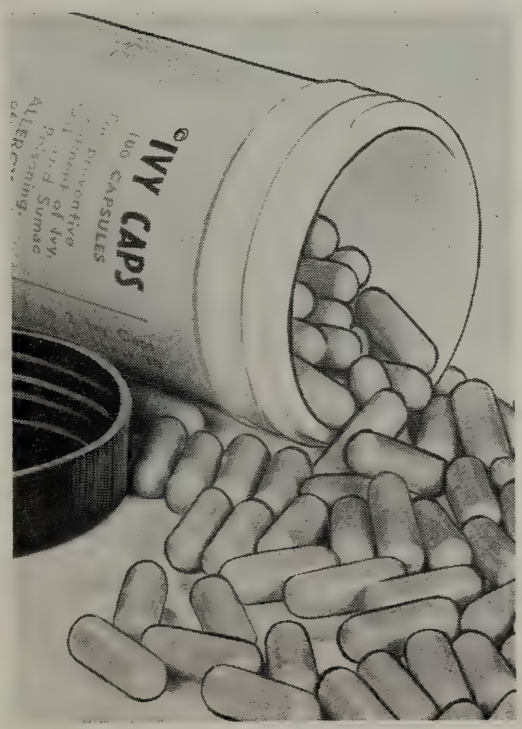
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text books are again being collected for World Medical Relief.

A James Bond Theme!

Not Ben Casey or Dr. Kildare but James Bond (no less!) provided the theme for the **Lucas County** auxiliary's dinner dance in February. The formal "007 party" was held at the Inverness Club, with Johnny Knorr's orchestra providing the music. Mrs. Robert Walker was chairman of the dinner dance, assisted by Mrs. Henry D. Cook, Mrs. Charles McGaff, Mrs. Jerry Draheim, Mrs. Wilbur Taylor, Jr., and Mrs. Everett Kasher. The regular February luncheon meeting featured the Rev. C. Umhau Wolf, pastor of St. Paul's Lutheran Church in Toledo, who spoke on "This is Jordan." Luncheon chairmen were Mrs. Cook and Mrs. Robert Barrett. New Study Groups getting under way include gardening (four sessions, Mrs. Miller Hallauer, chairman) and tennis (ten weeks of lessons arranged by Mrs. Joseph Roshe).

The **Stark County** auxiliary was honored recently by being awarded a "Gold Key" for outstanding 1965 volunteer work for the United Fund and its agencies. The presentation was made at Mergus Restaurant during the annual joint report meeting of the United Fund, its Health Foundation and the Canton Welfare Federation. Mrs. William A. McCrea, auxiliary president, accepted the Gold Key on behalf of her organization. The **Washington County** auxiliary honored its doctors recently with a Doctors' Day dinner at the Hotel Lafayette. Mrs. George Huston and Mrs. Ford Eddy were in charge of arrangements. The January meeting was a "guest day" with Carlos Germani, exchange student from Brazil, as the speaker.

Coming Up

Believe it or not, it's only about two and a half months to State Convention! Just doesn't seem possible. Be sure to see the April issue of *The Journal* for full details. Begin making your plans NOW to attend. Cleveland is the place. May is the month. And we're all looking forward to seeing YOU.

Carroll County Medical Society Announces Seminar Program

The Carroll County Medical Society has announced a complete program for its Second Annual Postgraduate Medical Seminar to be held at the Atwood Yacht Club, Atwood Lake, Route 1, Dellroy, across from the new Atwood Lodge, on Wednesday, April 13. Sessions begin at 9:30 a. m.

The program will be conducted by a team from the University of Cincinnati College of Medicine, with topics and speakers as follows:

The Diagnosis of Diabetes Mellitus — Dr. Harvey C. Knowles, professor of medicine.

Pericarditis — Dr. N. O. Fowler, professor of medicine and director of the Cardiac Research Laboratory of the University of Cincinnati.

Indications for Surgical Intervention of Duodenal Ulcer — Dr. John Wulsin, associate professor of surgery.

Problems of Teenagers — Dr. Norton Dock, assistant professor of psychiatry and associate professor of pediatrics.

Two half-hour round table discussion periods will also be a part of the program.

Reservations for the luncheon should be made with Dr. Thomas J. Atchison, 292 East Main Street, Carrollton, Secretary of the Society.

A complete day's program for the ladies is planned, including a visit to the House of Baskets, New Philadelphia, luncheon at the new Atwood Lodge, card playing, etc. A nominal registration fee will include cost of the luncheon.

Dr. Manuel E. Lichtenstein, Chicago, was guest speaker for the February 8 dinner meeting of the Fort Steuben Academy of Medicine in the Fort Steuben Hotel, Steubenville. His topic was "The Clinical Differences Between the Two Halves of the Colon."

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Hyperbaric Symposium Sponsored By Maumee Valley Hospital

Maumee Valley Hospital, 2025 Arlington Avenue, Toledo, will sponsor a one-day symposium on Hyperbaric Therapy, Thursday, March 31. The program, beginning at 9:00 a. m. at the hospital, will include lectures by internationally known physicians who have made outstanding contributions to the field of Hyperbaric Oxygenation.

The symposium has been planned to acquaint physicians with the recent advancements in this field. There is no registration fee. This program is acceptable for Continuation Study Credit by the American Academy of General Practice.

Program Director of the symposium is C. Robert Tittle, M. D., director of internal medicine and medical education at Maumee Valley Hospital. He will be assisted by Gilbert B. Stansell, M. D., director of laboratories at the hospital.

Speakers for the morning sessions will include Herbert A. Saltzman, M. D., Department of Medicine, Duke University Medical Center, Durham, North Carolina, discussing "Physiology and Current Medical Application of Hyperbaric Oxygenation." He will be followed by Orliss Wildermuth, M. D., Department of Radiation Therapy, Tumor Institute of the Swedish Hospital, Seattle, Washington, discussing "Radiologic Application of Hyperbaric Oxygenation." These lectures will be followed by a question and discussion period.

Following luncheon at the hospital, Claude Hitchcock, M. D., Department of Surgery, Minneapolis General Hospital, Minneapolis, will discuss recent "Surgical Applications of Hyperbaric Oxygenation." "Clinical Research in Hyperbaric Oxygenation," of current interest, will be discussed by Julius Jacobson, M. D., Department of Surgery, Mt. Sinai Hospital, New York, New York.

The afternoon session will conclude with the four lecturing doctors and Dr. Stansell holding a panel question and discussion period. Following the adjournment, the doctors will have an opportunity to inspect the Maumee Valley Hospital Hyperbaric Unit.

For further information contact C. Robert Tittle, M. D., director of internal medicine and medical education, Maumee Valley Hospital, 2025 Arlington Avenue, Toledo, Ohio 43609.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during January. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

Athens
Philip D. Kinnard, Athens

Auglaize
Barbara Cummins, Wapakoneta

Butler
Russell L. Malcolm Jr., Middletown

Clark
John S. Hopping, Springfield

Columbiana
Laszlo J. Bujdoso, Lisbon

Crawford
Stephen I. C. Kim, Galion

Erie
Allen B. Easton, Sandusky

Greene
Clayton E. Culbertson, Yellow Springs
Enrique Martinez, Xenia

Hancock
Oscar M. Weaver Jr., Findlay

Knox
Malcolm J. Jones, Mt. Vernon
Zolton Kontz, Mt Vernon

Lake
Frederick C. Kluth, Painesville

Logan
Glen E. Miller, West Liberty

Mahoning
Benjamin P. Brucoli, Youngstown
William Roy Johnson, Youngstown
Loren J. Zehr, Youngstown

Marion
Ralph E. Beck, Marion

Miami
Alfred R. Davies, Troy
Peter E. Nims, Troy
Kenneth E. Smith, Troy

Montgomery
Bernard J. Liddy, Niagara Falls, New York

Muskingum
Paul E. Hartenstein, Zanesville

Richland
Nabil G. Fahmy, Mansfield
Joel E. Kaye, Mansfield

Stark
Charles A. Belisle, Canton
Francisco J. Martija, Alliance

Summit
Eduardo Garcia-Rubio, Akron

Tuscarawas
Emmanuel J. Cassiano, New Philadelphia

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MR. HERBERT E. GILLEN, *Administrative Assistant*

PERRY R. AYRES, *Editor*

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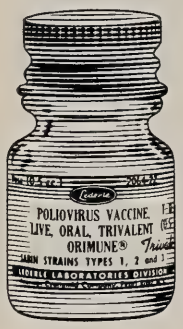
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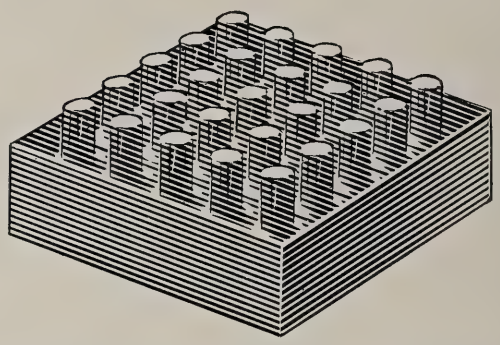


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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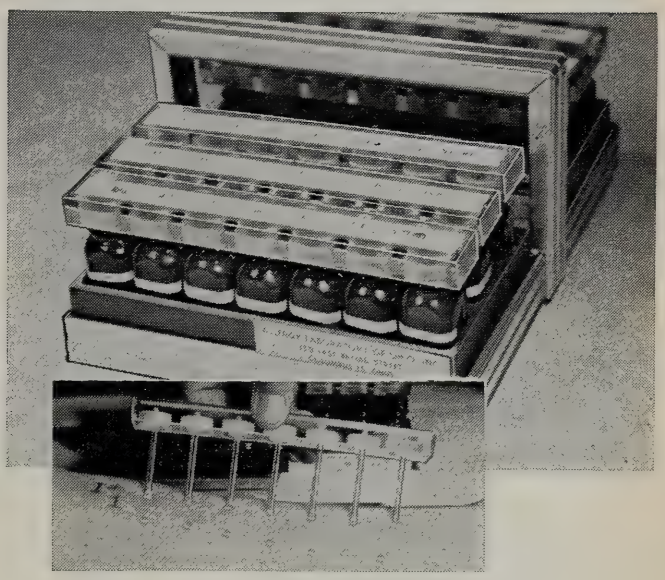
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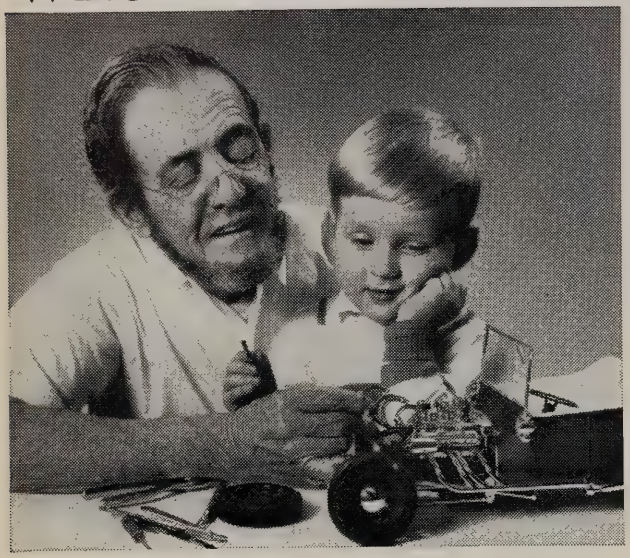
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Caution should be taken when treating patients with a low convulsive threshold. Patients should be warned not to exceed recommended dose which offers maximum effectiveness.

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Cincinnati Surgery Team Pioneers in Clinical Use of Argon Laser

University of Cincinnati Medical Center surgeons in the Laser Laboratory at Children's Hospital reported the successful first use of an argon laser to remove a melanoma and to treat a tattoo, both on human patients.

The January 24 operation was on a 45-year old man, who was sent to the Cincinnati laboratory for treatment by the National Cancer Institute, Bethesda, Maryland.

Dr. Leon Goldman, director of the Laser Laboratory and head of the University's Department of Dermatology, reports these first operations were successful.

The argon laser sends a continuous beam of light which can be more easily regulated and controlled than the burst of light from other types of laser. The University of Cincinnati surgeons used a curved mirror to aid in manipulating the laser beam. For comparison the surgeons also treated other tumors on the man with a ruby laser beam and with electrosurgery. A second patient had a portion of tattooing removed by the argon laser.

Developed by Bell Telephone Laboratories in Murray Hill, N. J., the argon laser was sent to the Cincinnati laboratory with Bell technicians for this research.

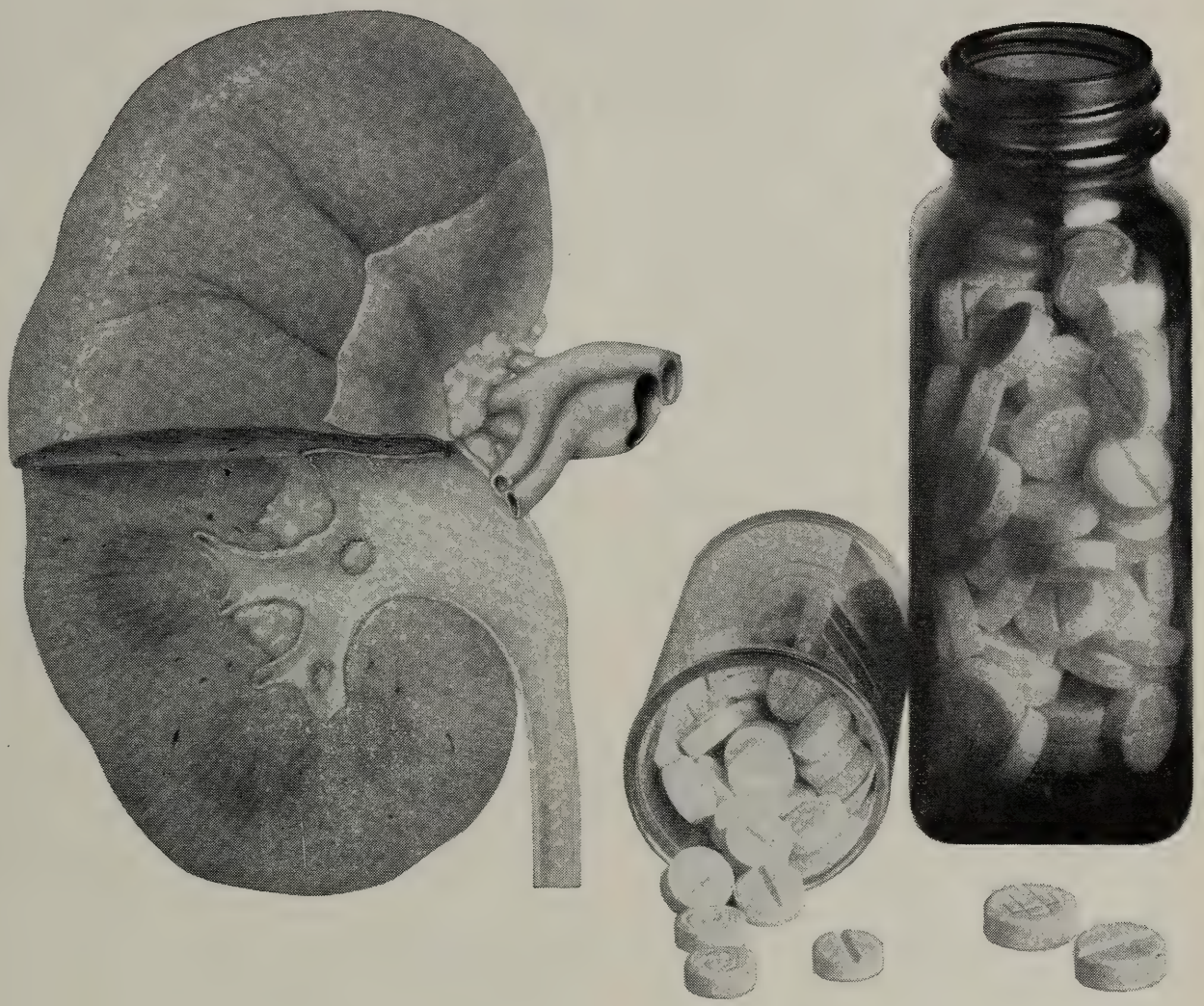
Dr. Goldman further announced that an argon laser is being donated to the Cincinnati laboratory by the John A. Hartford Foundation, New York City, which supports the entire work of the Laser Laboratory. Since the University of Cincinnati also does research toward protection of laser personnel, the staff will continue these studies in regard to the argon laser. The surgeon now must focus the beam, working from behind an amber plastic screen.

The operation was performed by Dr. Thomas E. Brown, head of the laboratory's neurosurgical work (under Dr. Robert L. McLaurin, University of Cincinnati professor of surgery); Dr. Goldman, and Dr. Bruce Henderson, fellow in pediatric surgery (under Dr. Lester Martin, Cincinnati associate professor of surgery) and in laser surgery (under Dr. Vinton E. Siler, Cincinnati professor of surgery).

Dr. William A. Altemeier, head of Cincinnati university's department of surgery, had appointed Dr. Siler to direct laser surgery at the laboratory. This is the first department of surgery in the nation which has a division of laser surgery. Dr. Goldman opened the nation's first Medical Laser Laboratory at the University of Cincinnati three years ago.

A consumer survey by the Pharmaceutical Manufacturers Association showed that while most people think prescription drugs cost too much, 82 per cent of those interviewed said their last prescription did a good job and 70 per cent said it was worth the cost.

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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where today's theory is tomorrow's therapy

Levi Rogers

Frontier Doctor, Pastor and Statesman

PHILLIPS F. GREENE, M. D.*

PART III

(Concluded from March Issue)

ABOUT JUNE 1st Levi rejoined the 19th Infantry at Camp Bull, Chillicothe. He reported to John B. Campbell, Col. by brevet, then in charge. Dr. Rogers had by now accumulated quite a number of bills for travel expenses, etc. He was told he must present them to the paymaster in Cincinnati. Finding none of his charges were ill, Dr. Rogers obtained a ten day leave from Col. Campbell and arranged for Dr. Spurch, surgeon's mate of the 26th Infantry to cover for him. He did not actually introduce Spurch to Campbell.

Upon his return to Chillicothe June 14th all seemed well. But soon a train of events started that ended in Surgeon Rogers' dismissal from the army. A newly arrived Kentucky volunteer had died while Rogers was on leave. His first word of this was a note from Col. Campbell dated June 17th, informing Rogers that Campbell had not considered Spurch competent for serious cases and had called in Dr. Monet of Chillicothe. Campbell instructed Rogers to pay Dr. Monet. Levi at once contacted Monet, whom he knew well and learned that the recruit had died of jaundice in Dr. Monet's home. Dr. Monet of course declined to accept money from Dr. Rogers for his services.

But Dr. Rogers felt Dr. Spurch had been unfairly treated, especially as Col. Campbell had made some slighting remarks in public concerning Spurch's abilities medically. Rogers wrote a very careful note to Col. Campbell raising this point. The Colonel replied that he himself, not the medical profession was responsible for the health of his troops and he would use his own judgment. (For over a hundred years this view was commonly held in our army. Not till the medical corps was finally organized under its own medical superior officers was it laid to rest.) But back in 1813, Levi Rogers felt he must press the issue. There followed an exchange of letters, each getting more irate. In his last letter to Col. Campbell dated June 21, Rogers practically ordered his superior officer to reply at once. Col. Campbell did not reply at all. On June 23rd Rogers sent a full report of the whole affair to the Hon. John Armstrong, Secretary of War. He seems never to have had a reply from that either.

Early in July 1813 the British forces were again preparing to take Ft. Meigs. Surgeon Rogers was sent back with a contingent of the 19th Infantry. He was the surgeon in charge during the second siege, July 26-31. This also ended by the British withdrawing.

During the following weeks the Fort was under no enemy threat. The main American military activity was building a navy for Lake Erie. Apparently Col. Campbell chose this time to get rid of Rogers. Early in September Rogers was arrested for "crimes and misdemeanors."[8] He was tried by a military court of inferior ranking personnel, his own witnesses were refused permission to testify, were not even sworn in. While the trial was in progress the news of Perry's victory over the British fleet arrived and the camp went wild in celebration. The court hastily found Surgeon Rogers guilty, set September 30th as his dismissal date, and rushed out to join in the celebration.

Early in October the army moved away leaving only a skeleton staff and the sick and wounded at Fort Meigs; Dr. Rogers was requested to remain to care for these. He felt he should stay and did so. An eloquent bit of paper on file in Washington is a testimonial from the three ranking officers at Ft. Meigs at this time.

To the Hon. John Armstrong, Secretary of War:

> We certify that when the Army moved from this place all the sick which were numerous, were left here. Dr. Rogers was requested to attend them which has been done with great attention and success by which he has the confidence and thanks of the officers and men at this garrison.
>
> Capt. Daniel Corner, commandant
> Lt. Thomas Dunn
> Ens. Ophraim

There is another document in Washington, — a memorial by Dr. Rogers written at Ft. Meigs, Nov.

*Dr. Greene, New Richmond, is a member of the staff, Brown County Hospital at Georgetown; Yale in China, emeritus Professor of Surgery.
Submitted February 3, 1965.

2, 1813, to the Secretary of War, begging for a review of his court-martial. After describing the whole proceeding and asserting his innocence he concludes:

> This is worse than death to a man whose whole life has borne marks of public esteem and confidence. Your memorialist hopes that the whole proceedings may be viewed by the President of the United States and justice done.[9]

I have been unable to find any record that this memorial was ever acted upon. This court-martial is missing from the official records of courts-martial held during the War of 1812. Maybe it was never officially reported to Washington. Levi Rogers was obviously still serving at Ft. Meigs weeks after the date officially recorded for his dismissal. He considered trying to contact both Gen. Harrison and Gen. McArthur to ask for their backing but decided against it, because it was so difficult to locate them and because "in time of this war they were giving their whole effort to the struggle."[10]

Rogers' original appointment had been for one year. Early in 1814 he was back home in Bethel, Clermont County, Ohio. Medicine became his chief occupation, though he was also elected a trustee of Tate Township where Bethel is located, and was serving in that capacity when he so suddenly died. He left his widow, two sons and five daughters. Many were the tributes paid him. "A great loss to our community. A man of singularly good judgment, "[11] said one of his legal colleagues and near neighbor, Thomas Morris, later U. S. Senator from Ohio.

During his last months of life, Levi had given special attention to training his second son John George Rogers in medicine. After his death, the Rev. George C. Light was able to persuade Dr. William Wayland of Circleville to come to Bethel, take over Levi's practice and continue the medical education of John George.

Anyone who has read this account cannot have missed the fact that Levi Rogers was a man of keen intellect and unbounded energy. He lived a life of great service and devotion to the country and the people of this state. His sudden death must have been widely noted. I fully expected to find an appropriate obituary somewhere. So far no obituary has come to light, either in the press of his day or in the Ohio records of the Methodist Episcopal Church.

Although he was well qualified in the three fields of religion, medicine, and law, and was involved in all three throughout his adult life, medicine was clearly his chief vocation. After the age of 27 when he resigned as a regular pastor of the M. E. Church, his preaching, performing of marriages and conducting funerals were all by way of aiding situations and meeting needs as occasion arose, rather than as a full time minister of the gospel.

Outside of his elected offices, his legal work was largely acting as executor for estates of people who had been his patients, and this usually without changing their estates, in the case of poor people.

Medicine was his chief calling. Nothing to my mind, shows more clearly his devotion to the ill than his continuing to care for the sick at Fort Meigs after he had been dismissed from the U. S. Army by the decision of a vindictive, crooked court-martial. His willingness to forego seeking the aid of powerful friends like Generals William H. Harrison and Duncan McArthur because he did not want to trouble them while they were making every effort to prosecute the War of 1812, shows a degree of unselfishness truly great. Finally his willingness to let the whole matter drop and return to his medical practice in Clermont County is indeed, "forgetting the things that are behind and pressing on to the high calling," to which he had dedicated his life.

Acknowledgment: Special mention of help received should be mentioned in the case of Lucile Hook, formerly Librarian of the Cincinnati Historical Society and Dr. Frank B. Rogers, Librarian of the Surgeon General's Medical Library, Washington, D. C., himself a descendent of Levi Rogers.

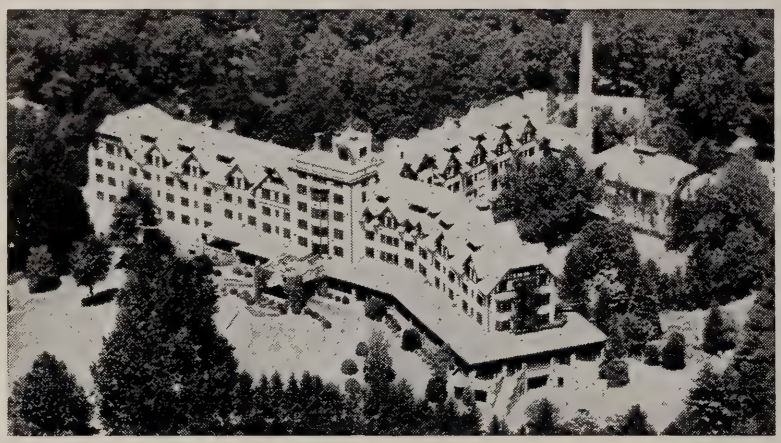
References

8. U. S. Army Records, Washington, D. C.: Levi Rogers file.
9. Rogers, L.: *Memorial to Hon. John Armstrong.* Now in Archives, Bureau of Special Services, Washington, D. C., Nov. 3, 1813, (Unpublished).
10. Levi Rogers file, same as Ref. No. 8.
11. Everts: p. 142.

CAMP ITCH.— Insufficient evidence remains to determine the exact nature of camp itch. It may have been scabies as many Northern observers maintained. However, as true Southerners, we must stand with Guild and Claiborne and conclude that camp itch was a distinct, noncontagious, pruriginous dermatitis resulting in some way from the vicissitudes of combat and leading to disability of great numbers of troops during the Civil War. — E. Randolph Trice, M. D., and R. Campbell Manson, M. D., Richmond, Va.: *Southern Medical Journal,* 59:10-14, January 1966.

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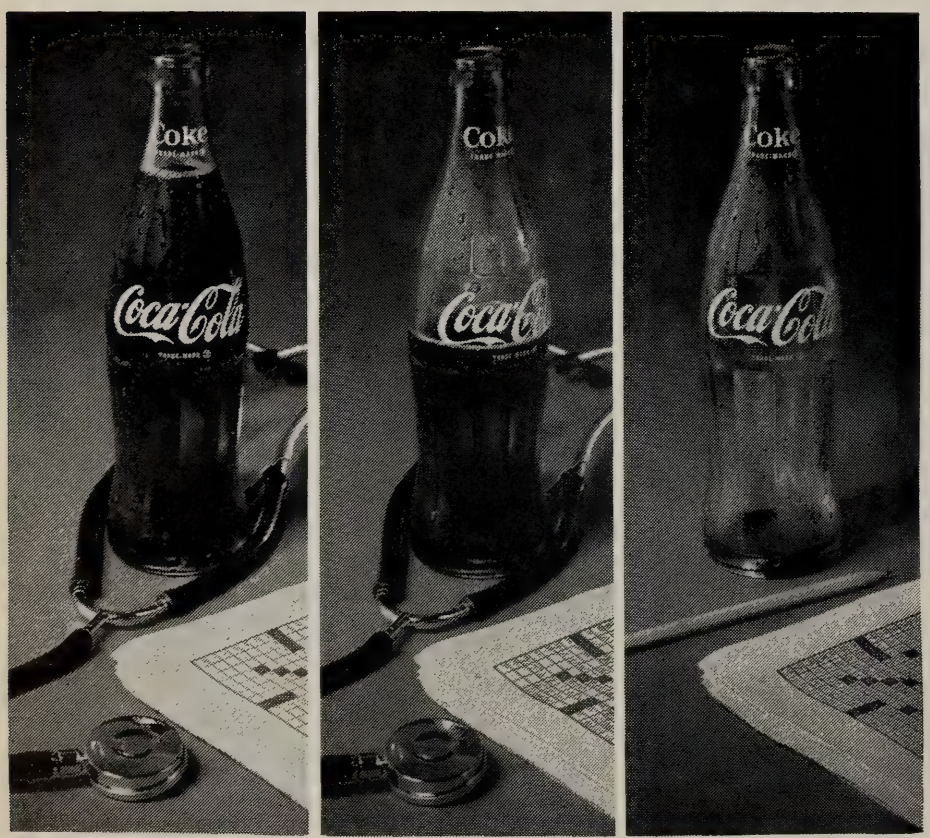
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Cyanocobalamin	1.5 mcg.
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Contains 15% alcohol

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Each MEDIATRIC Tablet or Capsule contains:

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Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
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*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

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6629

The Ten Commandments

For the Prevention of Alcoholic Addiction

TO ENJOY ALCOHOL SAFELY:

1. NEVER take a drink when you "NEED" one.
2. SIP SLOWLY. Space drinks: The second thirty minutes after the first; the third an hour after the second; NEVER a fourth.
3. DILUTE drinks — never on the rocks.
4. Keep accurate record of amount and number of drinks. Never drink every day.
5. Do not minimize the amount you drink. Instead, exaggerate it. If you say you drink twice as much as you think you do, this will probably be nearly accurate.
6. Do not drink on an empty stomach.
7. No signal drinking such as "luncheon," "Left office," "on the way home," "before dinner," before bed," "meeting people," "celebrating," and "to get me through."
8. Tired or tense? Soak in a hot tub.
9. Never drink to escape discomfort.
10. Never drink in the morning.

By understanding this dangerous, pleasant drug and observing precautions, many people may enjoy the use of alcohol.

Alcoholism is a psychophysical addictive disease to which all people are liable. It occurs in individuals who are physically pre-disposed and emotionally conditioned. The change from being non-alcoholic to alcoholic occurs suddenly, is seldom recognized, and is due to a breakdown in organic and psychological protective mechanisms. Once it has occurred, it cannot be reversed — then only total abstinence will save the individual.

It is possible for those who have not become alcoholic to enjoy the use of alcohol in this alcohol-oriented culture. Only they can prevent their becoming alcoholics, and to a large extent only they can prevent their children becoming alcoholics.

These ten commandments have been prepared as a leaflet by William B. Terhune, M. D., Medical Director, The Silver Hill Foundation, Box 1177, New Canaan, Connecticut. The author will supply copies for distribution free of charge.

A new million-dollar shellfish research center for the U. S. Public Health Service will be built in the Pacific Northwest, on the lower Puget Sound. Its 45-man staff of scientists and technicians will gather information on the role of shellfish in the transmission of disease and the effect of commercial processes on their sanitary quality.

Dr. James B. Overmier spoke on the topic, "The Heart" at the guest night meeting of the Town and Country Child Conservation League in Leipsic.

Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

* * *

Ill-advised statements and actions since the thalidomide phenomenon, aided by the unbalanced perspective given these statements in the lay press, have contributed to the public's apprehension — approaching hysteria — concerning the side effects of drugs. To the extent that this concern admonishes greater caution and alertness in the use of drugs, some good may be salvaged from the thalidomide tragedy. But to the extent that it deprives patients of useful new drugs or frightens a physician into withholding needed therapy from his patients, it is regrettable. We must not forget that there is no progress without risk, whether it be in the field of electricity, the motor car, the airplane, atomic energy, space exploration, or drugs. Even a bathtub can be perilous, as astronaut John Glenn discovered.—Theodore G. Klumpp, M. D., in *Massachusetts Physician,* (28:207-208), June-July 1965.

* * *

May I earnestly recommend, therefore, that general practitioners assume as a professional responsibility the obligation of recording their personal experiences with individual drugs. It is my hope that they will pass along their conclusions, based on collective experiences, to the companies who develop and produce those drugs. It is also my hope that they will pass along such data to the Food and Drug Administration when and if the occasion warrants. May I reiterate that as members of a great profession general practitioners have a responsibility not only to their patients today, but the patients of tomorrow and to the most important mission on earth, the discovery of new agents to conquer the still unconquered diseases that afflict mankind. — Theodore G. Klumpp, M. D., in *GP,* (32:211), November 1965.

* * *

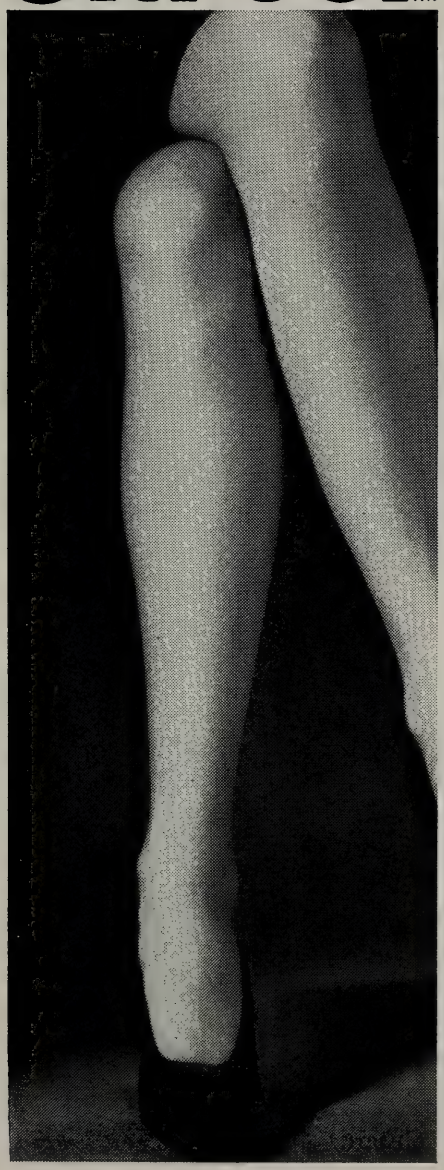
The samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item. — Editorial in the *Journal of Medical Society of New Jersey,* (62:547), December 1965.

* * *

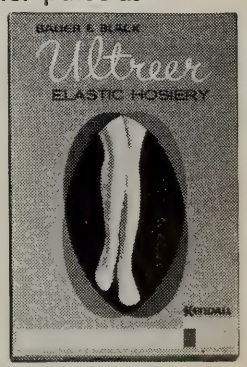
Without protection of the U. S. patent laws, it is doubtful if drug firms would have spent the money which produced cortisone, tolbutamide, isoniazid, chlorothiazide, broad spectrum antibiotics and many other wonder drugs of today.

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Elastic Stockings so sheer they look like support hose. Both Ultreer and support hose are sheer, shapely, cool and comfortable. But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. They provide the therapy you prescribe. The fashion and economy she demands.
Ultreer stockings have a new low price. So low, she can afford two pairs of Ultreer instead of one pair of regular elastic stockings. There'll be no disagreements there. Ultreer stockings are as comforting to her purse as they are to her legs. New Ultreer are the elastic stockings doctors and women can agree on.



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Work Days Restricted by Illness In Billions, Report Shows

During the 12 months ending June 1964 the civilian population of the United States, exclusive of persons residing in institutions, experienced 3.0 billion days of restricted activity due to illness or injury. The average person cut down his usual activities for 16.2 days during the year. Included in the days of restricted activity were 1.1 billion days spent in bed, or a rate of 6.0 days of bed disability per person per year.

Illness or injury caused 385.2 million days lost from work, or 5.5 days per currently employed person per year. (For the purposes of the Health Interview Survey, current employment is defined as working at any time during the 2-week period prior to the week of the household interview, or having a job or business during that period.)

Children aged 6-16 years missed 204.4 million days of school because of illness or injury. The average child lost 5.0 days from school.

As age increased, rates of disability days also increased. In general, the age pattern was similar for males and females, except that rates for females usually exceeded those for males. However, among males aged 45 years and over, the rate of time lost from work exceeded that for currently employed females.

Persons residing in nonmetropolitan areas had higher rates of restricted-activity days, bed-disability days, and time lost from work than did residents of metropolitan areas. The rate of time lost from school however, was higher for persons aged 6-16 years living in metropolitan areas than elsewhere.

Among persons living in nonmetropolitan areas the rates of reduced activity were about the same in farm and nonfarm sectors. Nonfarm residents had a higher rate of bed-days and of time lost from school. Farm residents had a higher rate of time lost from work than did nonfarm residents.

With increasing family income groups up to $10,000, the rates of disability days due to illness or injury declined for each type of disability except time lost from school. In the income group $10,000 and over, the rates of disability were about the same as those for persons of a $7,000-$9,999 family income.

Persons who were unemployed had higher rates of restricted activity and bed disability than did currently employed persons. — *U. S. Public Health Service "Disability Days."*

Dr. William A. Altemeier, professor and chairman of the Department of Surgery at the University of Cincinnati College of Medicine, received an $8,000 grant from the American Cancer Society to further his research in the use of nitrogen mustard.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during February. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

Ashland
Emmert C. Lentz, Ashland

Ashtabula
Richard L. DeCato, Ashtabula
Morris Wasylenki, Ashtabula

Cuyahoga
Virgilio T. Collantes, Cleveland
Max H. Kent, Cleveland
Seymour Liberman, Cleveland
Ronald J. Ross, Cleveland

Delaware
William N. Henderson, Delaware

Franklin
Richard M. Ward, Columbus

Gallia
Gerald E. Vallee, Gallipolis

Hamilton
Emmit F. Ackdoe, Cincinnati
Zol F. Muskovitch, Evansville, Indiana
Marjorie M. Porter, Cincinnati

Lorain
Charles G. Adams, Vermilion

Lucas
Thomas D. Saurwein, Toledo
Robert E. Youngen, Toledo

Mahoning
Jose L. Solana, Youngstown
C. Conner White, Jr., Youngstown

Marion
Frank V. Apicella, Marion

Miami
Albert C. Howell, Tipp City

Richland
James W. Wiggin, Jr., Mansfield

Sandusky
Eugene F. Dierksheide, Fremont

Stark
Christopher M. King, Alliance

Van Wert
Wilmer L. Iler, Van Wert

Williams
Neil T. Levenson, Bryan

Ohio State Pioneers in Network Nursing Education Program

Faculty of Ohio State University School of Nursing and the nursing service department of University Hospitals has launched a pilot continuing education program for nurses over radio-telephone.

The program is heard from 2 to 3 P. M. on scheduled days and is heard in hospitals already participating in the Ohio Medical Education Network, which originates from WOSU-FM. Nursing staffs of the following hospitals hear the program: Miami Valley, St. Elizabeth, Grandview and Wright-Patterson, all in Dayton; Piqua Memorial, Piqua; Lancaster-Fairfield, Lancaster; Marion General, Marion; Mercy and Springfield City, both in Springfield; Mercy Memorial, Urbana; Newark City, Newark, and Grant, Columbus.

Network for these programs permits nurses in participating hospitals to ask questions of the speakers. Sponsors believe the Ohio State venture is the first two-way continuing education program for nurses in the United States.

Each member hospital receives 35 mm, colored slides in advance of the programs. Speakers indicate which slide they want shown as they proceed with their presentations.

Campus area nurses and students hear the programs at the scheduled hour in Room 100, Starling Loving Hall. Two radio stations, WVUD-FM, Dayton, and WOSU-FM, Columbus, serve participating hospitals.

To All My Patients

"I did not write the medicare bill.

"I am not sure I understand it.

"I am not a government official.

"I was not trained in political economy.

"If you are not satisfied with your present, (1) medical costs or services, (2) hospital availabilities or cost, or (3) the cost of your drugs there isn't much reason to talk it over with me — I am probably as dissatisfied as you are and probably much more confused.

"There isn't much point in discussing with me the problems you have as a result of getting a whole new system of laws (regarding your medical care) to live by, because I don't yet understand what it is all about either.

"May I humbly suggest, if you have a problem (and I sincerely hope you do not) that you write your representative or senator in the United States Congress. Most of them knew enough about the law to vote for it, and perhaps since they knew so much about it when it was voted on, they can give you answers to all your questions now. I can't.

"Since my profession . . . is coming more and more under the control of the elected and appointed officials in Washington, D. C., please do not expect me to become less and less a doctor. I can't. I won't. Therefore, the economic-legal-political questions that are troubling you should be taken to the experts in those fields for an appropriate answer.

"In the meantime, remember me as the one who treats your arthritis, your blood pressure, your aches and pains. The one who is concerned with your long and comfortable physical life and — I hope — your mental stability in these trying hours." — Original Source: *St. Louis County (Mo.) Medical Society Bulletin.*

M. D.'s in the News

Dr. Donald M. Hosier, director of the cardiac laboratory and clinic at Children's Hospital in Columbus, spoke at the Heart Association workers' tea in Newark during the recent heart fund campaign.

* * *

Dr. John C. Drake spoke at a meeting of the Inter-Church Activities Committee at the Gay Street Methodist Church in Mount Vernon, where he discussed ethical and moral considerations in areas of medicine and religion.

* * *

Dr. Oscar W. Clarke, Gallipolis, addressed the Rio Grande PTA group, where he discussed diseases of the heart as part of the Heart Month program.

* * *

Dr. John J. Grady, member of the board of directors of the Academy of Medicine of Cleveland, spoke on "Alcoholism" at a meeting of the Ward 33 Republican Club, in the Cleveland area.

* * *

Dr. Harriet E. Gillette, assistant director of physical medicine and rehabilitation at Cleveland Clinic, discussed "Comprehensive Programs for the Handicapped" at the annual Lima and Allen County Cerebral Palsy Clinic dinner.

* * *

Dr. Norman S. Brandes, Columbus, has been named president-elect of the Tri-State Group Psychotherapy Society, an organization of group therapists from Ohio, Kentucky, and Indiana.

Tuberculosis mortality, which established a new low of about four per 100,000 population in 1964, continued at that level in 1965. Two decades ago, the mortality rate from this disease was ten times as high. — *Metropolitan Life.*



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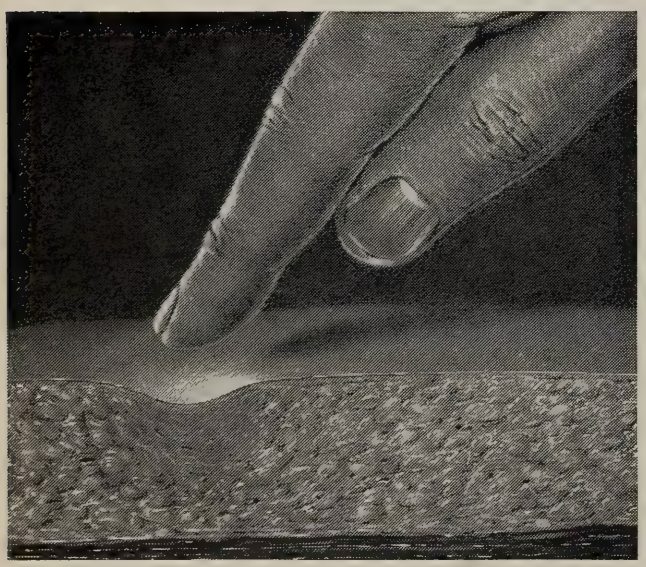
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WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Smoker Death Rate Tie Shown Among GI Policyholders

Cigarette smokers among 250,000 U. S. Veterans observed for more than eight years of a ten-year study by the Public Health Service continued to have a higher death rate than non-smokers. Among the causes of death tabulated, only Parkinson's disease was associated with significantly lower mortality for smokers.

Death rates for cigarette smokers were seen to remain fairly constant over the 8½-year period, while rates for non-smokers went down.

Findings of the nearly completed study show that, in the same age group, 11 times as many cigarette smokers as non-smokers died of lung cancer, and 12 times as many died of emphysema. Three or more times as many cigarette smokers as non-smokers died of cancer of the mouth, pharynx, esophagus or larynx, and such diseases as bronchitis, asthma, stomach ulcer, duodenal ulcer, and nonsyphilitic aneurysm of the aorta.

Study results showed mortality risk related to the amount smoked for each form of tobacco use. The risks for cigarette smokers greatly exceeded those for pipe or cigar smokers, and were lower for those who stopped smoking than for those who continued.

Results to date from the study begun in 1954 in cooperation with the Veterans Administration are reported in a monograph, *Epidemiological Studies of Cancer and Other Chronic Diseases,* just published by the National Cancer Institute.

The group of veterans studied are policyholders of U. S. Government Life Insurance. Nearly all are white males mainly from the middle or upper socio-economic levels.

USPHS Purchases Measles Vaccine For Local Preschool Programs

The U. S. Public Health Service will buy at least one and one-half million doses of vaccine during the next year to protect preschool children against measles, Surgeon General William H. Stewart announced.

The vaccine will be offered to health departments receiving project grants under the national Vaccination Assistance Act. Gamma globulin will be used in conjunction with the vaccine to minimize reactions.

The purchase was made in connection with the Service's cooperative effort with State and municipal health departments to eradicate measles. Since the licensing of the measles vaccine in 1963, some 12 million doses have been given in the United States, and the number of cases of measles has dropped from 385,000 cases reported in 1963 to 266,000 reported in 1965. It is estimated that reported cases represent only one-tenth of the actual cases.

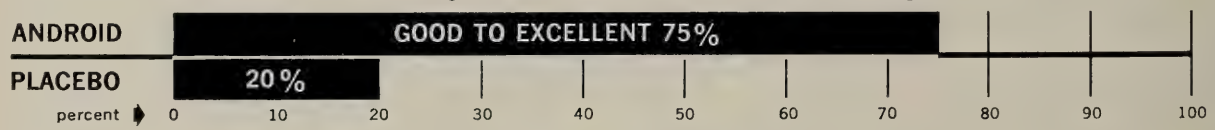
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4. No side effects in patients treated.
5. Alleviation of fatigue noted.
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

CONTRAINDICATIONS — Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease, hyperthyroidism. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

CAUTION: Federal law prohibits dispensing without prescription.

***"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.**

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Scientific Section

VOL. 62 APRIL, 1966 NO. 4

The Family Physician and Psychiatry

A Discussion of a New Method of Instruction

WARREN G. HARDING II, M.D., and WENDELL A. BUTCHER, M.D.

THE family physician has long recognized that a large proportion of his patients suffer from symptoms for which he is unable to find organic changes capable of explaining the disability of the patient. The amount of time consumed by these patients far exceeds their proportionate number. Conservative estimates by many men in practice have indicated that these psychiatrically oriented problems have occupied from 50 to 70 per cent of their time. The burden generated by the time factor is further complicated by the frustration suffered by the doctor as a result of his inability to understand the dynamics involved in these disabling syndromes. Many complain that so little training was given to them in their formal education in this field. Indeed, in many medical schools these diseases requiring a half of their professional time were given less than 10 per cent of the curricular time. Many of those who graduated prior to 1950 received less than 3 per cent of their instruction in psychiatric training. The purpose here is not to indict medical education for a lack of interest in this important field but to recognize that even greater efforts need to be made to expand the knowledge and insight of the young physician in this challenging discipline.

The most encouraging aspect of the problem is that a widespread recognition of the need is beginning to appear. The *AMA News* of April 19, 1965, pointed out that in the plans for the Board of Family Practice approximately one fourth of the required time would be devoted to Psychiatry. The Federal Government is sponsoring a program designed to establish Community Mental Health Centers in strategic locations over the entire United States. In Ohio, the Citizens Committee for Mental Health Planning has received the enthusiastic support of civic leaders throughout the state in a manner surprising to its most ardent advocates. The problem that everybody recognized but did nothing about is to be subjected to a positive approach aimed at solving it.

It is foolish to hope that regardless of the support of governmental agencies and an aroused citizenry there will be enough trained psychiatrists in the foreseeable future to relieve the family physician of the necessity of dealing with this type of patient. The genuine need is for the family physician to recognize the early symptoms pointing to emotional stress and, by instituting active therapeutic measures at this stage, to prevent the further development of mental illness. The trained psychiatrist's obligation is to be the consultant and the therapist in those severe and compli-

Submitted July 29, 1965.

The Authors

● **Dr. Harding, Columbus, is Administrator, and Director of Medical Education, Grant Hospital; Assistant Professor, Department of Surgery, The Ohio State University College of Medicine.**

● **Dr. Butcher, Columbus, is Clinical Assistant Professor of Psychiatry, The Ohio State University College of Medicine.**

cated cases that develop a need for prolonged therapy. The revered family doctor, who has been replaced by the specialist, recognized many of these developing symptoms. By counseling and supportive therapy, he was able to contribute much to his patient, though in most instances he neither gave the illness a name nor formalized it into any psychiatric classification.

The mobility of the population and the changing economic status of the people have abrogated the relationship between doctor and patient so that the modern family physician must be more alert and incisive in order to recognize these early changes potent for disaster. Armed with an encyclopedic knowledge of the blood levels of rare chemical substances in esoteric diseases, however, he often fails to recognize the early symptoms of a depressive reaction, possibly the most common psychiatric entity and the least recognized. Do you realize how high suicide stands in the statistics of death causes in the United States and how many "accidental deaths" are actually premeditated? Death is just as final whether it be from suicide or from a blocked coronary artery.

The family physician, frustrated by the enormous number of these difficult cases and cognizant of his inept preparation to cope with them reacts in one of three patterns. To some he gives a prescription for some sedative or mood elevating medicament in the hope that when they see him a miraculous improvement will be apparent. To a second group he will place a label of "crock" or some similar appellation and attempt to close his eyes to their needs. The remainder will involve him in their difficulties so that he will feel that he must find out the mechanics of their sickness and the most appropriate therapy to return them to a useful and happy life.

The source to which he can turn for help varies. Some go to a book and become lost in the minutiae and trivia of the theories and discussions. Some go to lectures, seminars, and postgraduate courses sponsored by the medical societies, universities and at times by lay groups. In many of these sincere efforts the family physician adds to his confusion by finding that the explanations given are too theoretical or too largely devoted to rare and unusual aspects of the problems to be of much aid to him in his daily practice. The study is directed to the advanced clinical picture rather than to its incipient manifestations where his active therapy may result in clinical improvement and prevent the development of serious incapacity. It is not the purpose here to indict any of these methods but to offer a different approach which is live, interesting, available and directed toward the family physician and the community hospital house staff.

The Case Forum

The hospital in which the following program has developed in the past year is a 400 bed general hospital. It does not have an organized psychiatric department, either as an inpatient or as an outpatient service. Five practicing psychiatrists serve on the staff in a consultative capacity. The hospital has a large emergency room service which receives approximately 1500 visits each month. Contagious diseases are not knowingly admitted.

A one hour psychiatric conference is scheduled bimonthly at one o'clock. All staff members are invited to attend and participate but the family practice section members are especially concerned with the material and presentations of the program. The method gives them an opportunity to take an active part in the educational program of the house staff where their ability to contribute in a substantial manner has long been neglected. The moderator of the conference, a psychiatrist of recognized standing in the community, invites a guest psychiatrist to share the discussion with him. The family doctor or a volunteer from any of the hospital services presents a case from his private practice who may or may not have been an inpatient in the hospital. The choice of patient is left entirely to this physician, though for purposes of organization, the general area of diagnosis such as depression, adolescent rebellion, eneuresis, and functional systemic symptoms is suggested. The consulting psychiatrists are not aware of the case prior to the conference.

The salient features of the history, physical examination, socio-economic background and the treatment are presented. The moderator may then probe for further information which may have been overlooked or thought to be noncontributory to the illness. It is not the purpose of the meeting to put the family physician "on the pan" but to aid him by guiding him into a method that will be of value in his future investigation of such complaints. The psychiatrists then discuss the various methods that may be used to treat the patient and explain the recommended treatment on the basis of the dynamics or organic concept of its origin. In most cases, where at all possible, one of them espouses one concept while the other argues as vehemently for the other. During this polemic, the staff may introduce questions in order to clarify the meaning intended where the psychiatrist has assumed too much understanding by the staff. In the informal atmosphere of this discussion, the engagement of the house staff in the discussion has been most satisfying. Their reaction has been that the subjects considered are those which they see on the wards, emergency room and outpatient department each day of their work. The greatest recommendation of the value of this session is the difficulty encountered in closing within the one-hour time limit. Try it and you will be convinced.

Medical Travelogue

About Artificial Organs, Kidney Transplantation, and Unrelated Medical Experiences in Europe, Fall, 1964

W. J. KOLFF, M.D.

ONE general lecture, "To Live Without Heart and Kidneys," and two more specific lectures, one about "Hypertension and Kidney Transplantation," the other about the "Artificial Heart Inside the Chest," gave me an opportunity to visit medical centers in Europe. The medical experiences of these visits are related in the following pages.

The Author

● **Dr. Kolff, Cleveland, is Head of the Department of Artificial Organs, Cleveland Clinic Foundation.**

London

Professor John McMichael made the arrangements for our short visit in London. I gave three lectures; two at the British Postgraduate Medical School and one for the London University, preceded by a tea. The most exciting thing I saw was the special heart care room at Hammersmith; it is an intensive care unit for patients with acute coronary attacks. Acute coronaries that come to Hammersmith Hospital go to this room while preference is given to bad cases. The patient is immediately connected with extensive recording equipment which can be followed in his room and which is put on tape in a central recording room, from where the patient can be observed via closed circuit television.

Immediately upon admission a small polyethelene catheter is inserted with Seldinger technique into the superior vena cava. At frequent intervals small amounts of dye are injected, and cardiac output is calculated according to the dye dilution technique, using an ear piece for recording. A needle is inserted in the brachial artery for continuous recording of the arterial pressure, and frequent recording of oxygen saturation of the blood.

A continuous record is also made of two leads of the EKG.

The Unit is in the department of Prof. McMichael, under direct responsibility of Dr. Shillingsford.

The staff is divided into clinical and research sections.

Since the special heart care room opened in December, 1963, twenty-nine patients with serious acute coronary attacks had been admitted. Not a single patient was lost, although a hospital mortality of 30 per cent should have been expected. Only one patient died later at home. Four patients were in ventricular fibrillation. Immediate closed chest cardiac massage and electroshock restored them. Two patients had malignant supraventricular tachycardia and were electrically converted. Two patients showed a syndrome described as being very ominous. Gradual fall in arterial pressure, slowing of the heart rate to 30, inversion of the P waves, and shortening of P-QRS interval until the P wave disappears and the QRS widens. The cardiac output fell to 2 liters per minute. Prof. McMichael thought that this might be a vagus effect, and atropine I. V. miraculously reversed the entire syndrome.

The significance of this approach to the treatment of acute coronaries is that the effect of therapy can be evaluated objectively. The patients that I saw were remarkably comfortable, although one had been resuscitated the night before.

Oxygen proved important for treatment, although in most instances it lowered the cardiac output. Morphine is deleterious. Some patients had low cardiac output, lowest was 2 liters per minute, but some had high cardiac output, 7.5 liters per minute.

Dr. McMichael took me to the technical workshop. Realizing the importance of a modern machine shop for modern medicine Hammersmith has given this first priority. The Alvarez heart valve, which was given to me in Madrid, was developed here. A later version, the Hammersmith valve, is also made of polypropylene. It has good flow characteristics as

From the Department of Artificial Organs of the Cleveland Clinic Foundation, Cleveland, Ohio. The work of the Department is supported by the John A. Hartford Foundation and by NIH Grant HE 4448, from the National Heart Institute.

compared to ball valves and the valve is being used clinically.

Amsterdam

The First Congress of the European Dialysis and Transplant Association was held in Amsterdam in September, 1964.

There were 20 centers in Europe where patients in chronic renal failure were maintained by repeated dialysis. This was more than in the United States at that time. Kidney transplantation is being done in many countries.

The Congress was superbly organized and, since I was a very early dialyzer, I was the guest of honor. I gave an address and was Chairman of a session.

The most exciting paper that I heard was by a Greek, Yatzidis. Whereas most of us discarded the idea of removing retention products from the blood with charcoal or resins because charcoal removes so little urea, Yatzidis took the attitude "so what." Thus, with a very small, inexpensive column of activated charcoal he removed large amounts of creatinine, uric acid, phenols, phosphates, and any other conceivable retention product. Urea was removed too, but only a few grams of it. This technique opens numerous possibilities. First, we will be able to differentiate the clinical effect of urea retention as compared to that of other substances. Second, post-dialysis oliguria might not occur with this type of artificial kidney.

The Dutch minister of education, Mr. Th. Bot, who has jurisdiction over all medical schools, was invited to the banquet. Since I shared the same school bench with him for one year and the same classroom for six years, it was a great pleasure to see him again. I had not seen him since 1930.

Stockholm

In Stockholm I met Clarence Crafoord, one of the founders of modern cardiovascular surgery and found him a delightful and very entertaining person. He is fully recovered from an accidental trauma with prolonged coma, which caused his colleague, Olivacrona, to open his skull three times. Eric Jorpes, who contributed much to the purification of heparin, without which no artificial organ can work, was much interested in our attempts to prevent clotting with negative electrical charges. After all, heparin, as he pointed out many years ago, consists of 40 per cent sulfuric acid and probably owes its anticlotting effect to its negative charge.

Radiology has always been far developed in Sweden, and I met Seldinger, the man who introduced a new way to catheterize blood vessels by pushing a catheter over a guide wire, which is introduced first through a venopuncture needle.

Dr. Bodo von Garrelts made a coil kidney in 1946, undoubtedly the first kidney of this type. He is an old friend and was my host. He has developed a simple electronic device to define the physiology of voiding. The patient voids in the solitude of a bathroom, but the weight change of the pot is recorded. The acceleration of the flow is computed. Urology is becoming very scientific!

Edinburgh

The contributions of Prof. M. F. A. Woodruff and of his laboratory to the field of transplantation are great. His associate, Mr. J. L. Roak, F. R. C. S. E., showed me the laboratory.

Prof. Woodruff's group is now concentrating on the role of immunologically competent cells for the possible treatment of cancer, endeavoring to induce a homograft reaction against transplanted mouse mammary carcinoma by the transplantation of preimmunized spleen and thoracic duct lymphocytes.

Mr. Roak is able to cannulate the thoracic duct of a mouse, using a small nylon or polyethylene cannula (Portex plastic tubing) and glue (Eastman 910), instead of ligatures. He obtains as much as 20 mls of lymph in the first 24 hours containing 100x1,000,000 lymphocytes. The mice are kept relatively happy, suspended over a wire wheel so that they can walk without making any progress and can reach food and water. This variation of a technique initiated by the now classic work of Gowans on lymphocytes opens new avenues for research.

Work conducted in the same laboratory by Howard, Roak, and Christie elucidates the origin and possible role of Kupfer cells in the liver. With the recognition of two identifiable chromosomes in the cells of C-57 black mice, the lymphocytes can be traced following transplantation, as can their offspring. By transplanting parenterally C-57 black mice lymphocytes into C-57 black $T6F_1$ hybrid mice and subsequently isolating the Kupfer cells from the liver, it has been demonstrated that cells within the sinusoids of the liver are 90 per cent of donor origin. Thus, it is claimed that the conversion of lymphocytes to macrophage can take place in the context of graft versus host disease. The lymphocytes were obtained from spleens or other sources. It is intended to repeat this work, culturing lymphocytes obtained by thoracic duct cannulation for 24 hours and subsequently injecting only small lymphocytes into the F_1, to demonstrate small lymphocyte to macrophage conversion.

Dr. Robson, in the nephrology section, demonstrated the sterile rooms in which patients were kept following total body irradiation. Infection in general is introduced with food, by contact with personnel, or is airborne. The airborne infection is minimized by a relatively inexpensive system of overpressured outside air taken from the rooftop.

Open culture plates placed in the sterile room produce only one colony per hour in contrast to several hundred in a ward. Personnel showers, changes clothes completely, and is most of the time separated from the patient by a glass wall. The loneliness of

the patient becomes a real problem. It bothered the patient to the point of distraction, when he could see the rain hit the window, but could not hear it.

Woodruff and Robson had the satisfaction that they have never lost a patient from aerogenous infection, but unfortunately several immunologically incompetent patients succumbed from bacteria they already carried with them. The lessons learned, however, are worthy to be applied to general patient care. In Stockholm, I had already observed a complete separation of clean and infected patients in the Department of Urology.

Robson has been fortunate in having obtained the cooperation of a charming woman pathologist who specialized in ultramicroscopic studies of the renal changes in diabetes. The early changes, which are later classified as Kimmelstiel-Wilson disease, can be detected in young diabetics as soon as the diagnosis is made and even before the need of insulin exists. I spent a fascinating hour with her reviewing her electron microphotographs.

The highlight of my entire trip was the Cameron Prize Lecture! Dr. Andrew Robertson Cameron left 2,000 pounds to institute the lecture in 1878. The third lecturer was Mr. Louis Pasteur. Since 1954 the prize has been awarded once every two years.

Closing the academic procession were Prof. Girdwood, Professor of Medicine, and myself in dark red robes. After Prof. Girdwood had explained the significance of the prize, the theatre was all mine. Both the audience and the occasion were inspiring! Title, "To Live Without Heart and Kidneys."

I was fortunate that I could present the work of our Cleveland Clinic Kidney Transplantation Team. We have the largest and, so far, the most successful series of cadaver kidney transplants. This is the more significant because so many others had given up the use of cadaver kidneys. I showed the film which features 14 bilaterally nephrectomized patients riding on a trailer over our farm and enjoying a picnic, thanks to functioning transplanted kidneys. It brought the message across that results may be worthwhile in terms of human happiness even when we cannot yet predict the duration of the useful function of the transplant.

Following the lecture, there was an official dinner, presided over by Sir Edward Appleton, renowned physicist, discoverer of the Appleton layer in the sky used for reflection of radio waves. The discovery brought him the Nobel prize. Sir Edward is principal of the Edinburgh University and a more inspiring man to dine with I have never met. A toast to the Queen, a toast to the Chancellor of the University (Prince Philip), a toast to the Cameron Prize winner, to his health, and a reply.

That night the dome of the University was flooded in honor of the Cameron Prize Lecturer.

Ghana

I know that Ghana is in Africa and not in Europe, but I made a little side trip. From Cleveland I had written to the President of the University of Ghana in Lagos (near Accra). It turned out that the President of the University is Kwame Nkrumah himself, and he ordered the Medical Society of Ghana to arrange a meeting for me in the hospital connected with the new medical school. Its beautiful new buildings were under construction.

The lecture room was filled. Three fourths of the doctors were Negroes and all were trained abroad. Most had functions at the medical school. I was impressed by the caliber of these men. One of them, Dr. Quartey, arranged a dinner at his house. His wife, for the occasion in Ghananian dress, European trained, and a charming lady, works as an operating room nurse.

Spain

The Fondacion Jiminez Diaz was a surprise to me. It is a private institution. Started 24 years ago, it now counts 120 members of the staff and 200 fellows. It has an outpatient department, a hospital of 500 beds and a research department. The Fondacion's buildings are new and beautiful, their equipment up-to-date. I saw, for example, brand new German equipment for renal scanning. The analogy with the Cleveland Clinic is obvious. It indicates that there is a place for good medical practice under many different systems. I was presented with three new mitral valves developed by Dr. Alvarez from the Fondacion when he was in England. These valves are hoped to allow larger blood flow than the Starr-Edwards valve.

The Fondacion has sent staff members all over the world to be up-to-date. We had three in Cleveland, among them Dr. de la Barreda and Dr. Sanchez-Sicilia who worked a year with Dr. Nakamoto in our department. The Fondacion has superspecialists much as we do, but they do not have the divisions with separate chairmen. Instead, there are many parallel departments each with a Jefe and an associado. For example there were five parallel medical departments. All of this is guided by the Director, don Carlos, which is how Prof. Jiminez Diaz is affectionately addressed. He is small in stature but a great man with a progressive forward looking interest in medicine.

I gave two lectures and a conference with much discussion. They are treating patients in chronic renal failure with repeated dialysis, had just started kidney transplantation, and were in need of some encouragement.

Dr. Hernando is Jefe of the Nephrology Unit and Dr. Sanchez-Sicilia, associado. The artificial kid-

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BALTIMORE

ney room looks out over the woods that belonged to the royal hunting grounds.

Paris

Professor Jean Hamburger, Hospital Necker, in Paris, has the largest experience with kidney homotransplantation in Europe. Since he was among the early workers he had already started when total body irradiation was used to suppress immune response. He can claim some very long time survivors. The longest survival in the world is a postal clerk in Paris, who received a kidney from his (nonidentical) twin brother (no demonstrable chimerism either) five years ago. Renal function is normal.

Equally good results have been obtained later, since Hamburger also began to use 6 M. P. (6 mercaptopurine) or Imuran, a derivative of 6 M. P. Of course, the survival times are not that long yet; they cannot be. They use more Imuran and less prednisone than we do. They nearly always suture the ureter over an indwelling ureteral catheter and only rarely implant it in the bladder. Patients transplanted less than one year are all reviewed once a week by the entire staff with Prof. Hamburger himself presiding. It is on a Thursday afternoon, and I sat next to Hamburger and looked over all the charts and all the data.

Since the patients were doing so well, it was a festive affair. At the time, they had 20 living patients (we had 21). They had far fewer cadaver kidney transplants than we have, but they are now pursuing this. They sometimes move a patient to another hospital to bring him close to a potential cadaver donor.

The law in France requires no permission from the family to remove the kidneys from a cadaver, but it requires the signatures from three physicians to declare that the donor is dead and according to the law they must prove it, which they do by cutting an artery and showing that no blood flows from it.

Hamburger's group, with Dr. Antoine and others, have studied immunological problems for years and go through extensive testing and typing for selection of live donors. Since, so far, we are more restrictive in the acceptance of living donors, we rarely have more than one or two donors to choose from, and therefore such testing would only have academic value. For the future it may become very important. Hamburger's group has recognized some late disease in recipients that nobody else has as yet seen. It is associated with hypersplenism. Therefore they now remove the spleen in every case. Since they don't have Dr. Crile in Paris, they cannot remove the thymus or most of it without thoracotomy and they leave the thymus alone.

I gave three lectures, two of which were in French. My French was not really French, but I got my points across and without reading from a paper.

Greece

Dr. Moulopoulos wrote his book, *Cardiomechanics* (published by Thomas) when he was in my department at the Cleveland Clinic. He was a productive investigator. When I saw his present setup, I remembered the words of Rutherford, "Since we have no money we have to think," and think he does! Young physicians are paid nothing or little, if they want to work in hospitals. Twelve hundred dollars a year would hire a full time researcher (M. D.) for Moulopoulos, if he had a small grant.

He has induced four groups of physicians, each consisting of four or five doctors, to work on research projects every Tuesday from 4 P. M. to 12 P. M. The times are not so strange since the day is cut in half by a siesta, and normal working hours for physicians are from 9 A. M. to 1 P. M. and 4 P. M. to 8 P. M. It occurred to Moulopolous and a Greek electrical engineer, that the normal rhythm of the heart and its generation might be explained as a system of natural oscillators with various frequencies. They made a model to demonstrate this, using 12 pendulums of varying length, trailing their tails through charged NaCl solution so that the resulting electro-(cardio)gram could easily be recorded. Thus they revived the work by a Dutchman, van de Poll, in the early thirties, brought to my attention as being brilliant by Sir Edward Appleton, who was mentioned before. If the heart were a system of electrical oscillators then it should be possible to put it in fibrillation, which is true, and the threshold to fibrillation might be influenced by putting a grid with a certain charge somewhere in the ventricle. Experiments in dogs to this extent I witnessed in Moulopoulos' laboratory at 11 P. M. It seemed that the threshold to fibrillation could be significantly increased.

The engineer hates the sight of blood and analyzes the curves in another room. Although this work was started as basic research, clinical application may not be far off. In one patient I have recently seen ventricular fibrillation recur within one and a half minutes all during the night, which necessitated electric shock every time. In the future such a patient might be saved if properly grounded platinum needles were put in the myocardium to form a grid.

A second group of Moulopoulos' investigators put radioactive strontium inside the ventricle and, with a Geiger counter, could record exactly the thickness of the ventricular wall during contraction of the ventricle. The influence of drugs on the contraction of an ischemic area produced by ligation of a coronary artery was studied. Strophantine was shown to increase contraction.

A third group of Moulopoulos' investigators led by a thoracic surgeon, replaced the function of right or left ventricle in a dog at will, in a carefully controlled fashion. The only reward the investigators

get is the possibility of writing a thesis. Moulopoulos' department produced six last year. The equipment is largely the same equipment (good and up-to-date) used during the rest of the week on patients. The laboratory space is a modern cardiac laboratory. The siesta period facilitates the conversion from men to animals. The specific equipment required for animal experiments is made from odds and ends. Instead of burets they use old bottles, upside down with the bottom cut off. The work is of high quality and articles have recently been accepted by *American Journal of Physiology,* by *Lancet,* and by other internationally known journals. "Since we have no money we have to think."

In Athens, I gave two lectures. Dr. Moulopoulos gave simultaneous translation in Greek. The technical equipment of the auditorium allows translation in four languages simultaneously. Meetings with visitors from many countries often take place.

Vienna

Prof. K. Fellinger was our host and Dr. Bruno Watschinger our guide and manager. Watschinger was coauthor of the twin-coil kidney developed in Cleveland. Fellinger is Rector Magnificus of the Alma Mater Rudolphina, the University of Vienna. The significance of the appointment lies in the fact that during his tenure the University celebrated its 600th anniversary.

In 1365 when the University was established, a medical faculty was also begun, but its fame came later when van Swieten, personal physician to Maria Theresa, organized the medical school and when her son, Josef II, (1780-1790) built a general hospital of 2000 beds. The hospital has two artificial kidney departments, one in the department of Urology situated in the surgical constant care unit and one in the Medical department headed by Dr. Fritzer, the successor to Watschinger. They are very well equipped, roomy, and, of course, well run. Professor Fellinger is particularly popular with such patients as the Shah of Persia, Ibn Shaoed, President Sukarno, and many other sheiks, Arabs, and Africans. He is an impressive man, moreover gay, and he prefers a weinstule over an international hotel. We could not agree more.

I gave two lectures, both in German, one for a meeting of the medical society of Vienna, held at the University. It was one of their regular meetings and first there were short papers by others. The first, which I thought was excellent, was about demonstration of phosphatase in electron microscopical slides and one was about an echo method to demonstrate hematomas and displacement of brain structures, especially useful after brain accidents. It takes less than three minutes, is not painful. This was developed in Vienna. Half a dozen neurosurgeons stood up to testify that they too used the method, much to the gratification of the patient.

München

Adolf Hitler, without knowing it or wanting it, did one good thing. He had built for himself a bomb shelter with walls of three meter concrete inside the garden of the hospital. It was complete with two operating rooms, et cetera, just in case he would be wounded while visiting Munich.

This bomb shelter has now become the experimental surgical laboratory for Dr. Brendel and, thanks to its walls of armoured concrete, it is free of vibration and electrical disturbance. Brendel and co-workers reduce the lymphocyte count in blood of dogs and rats by radiation of the animals' blood outside the body while it runs through a plastic tube. (The same technique has been used in leukemia.) A temporary lymphocytopenia results and, during this period, skin grafts in rats and kidney grafts in dogs last longer than usual. This is still another argument to indicate the importance of small lymphocytes in the rejection of homografts.

Unfortunately, a lymphocytosis follows the lymphocytopenia, which then leads to accelerated rejection. Brendel and co-workers have not tried to suppress this reactive lymphocytosis with Imuran.

Another way to destroy the lymphocytosis is first to do thymectomy and then to give total body irradiation. Some bone marrow removed before the irradiation is implanted and the result is an animal with leukocytes, but no lymphocytes. Tolerance for homografting is increased.

Brendel and co-workers explore the possibility of preserving kidneys for transplantation. It was found that dog kidneys stored at –6°C still have some phosphatase activity and one has to assume that this would gradually destroy the tissue. The conclusion is that for long term storage, the temperature must be lower than –6 C. Unfortunately, lower temperatures cause the formation of ice crystals inside the cells with total destruction of same. Glycerine is added to the solution with which the kidney is perfused to prevent crystal formation. When the kidney, 12 hours after perfusion with glycerine and cooling, was reimplanted in the same dog a disappointing experience occurred. The kidney swelled and burst. Others had suggested that slowly opening the arterial blood supply might help to prevent this. Tretbar and Figueroa have done the same in Cleveland.

Dr. Wolfgang Seidel, former Fellow in our department, and Dr. Hans Gurland, in charge of the artificial kidney in Munich, were our guides and managers. Professor Zenker had arranged a lecture for the University of Munich (in German). During and after lectures in Universities in Germany, approval is not indicated by clapping of hands but by knocking with knuckles on the tables. Disapproval is indicated by "scharren" (to shuffle your feet on the floor). In the afternoon a special meeting had been arranged

in which 14 of the leading kidney men from all of Germany were brought together with 14 kidney men from Munich, and I led a two hour conference and discussion on the basis of our experience in Cleveland.

I had never seen Erdhörnchen, small ground squirrels, the cutest little animals. They are true hibernators and since it was already quite cold in Munich they were already kind of sleepy and did not bite as much as in summertime. They can blame their presence in the University courtyard to the fact that rats, when refrigerated for two hours to under +10°C develop edema of the brain. The intracellular sodium in the brain goes up, the potassium goes down. Erdhörnchen do likewise in summer, but in winter they cannot possibly do so, or they would all die. They continue a healthy sleep at 5-6°C, but they have an inbuilt safety mechanism, which makes them wake up and move when they are cooled under 5°C, until they develop enough heat to prevent edema of the brain from developing. What is the essential difference between the rat and the wintering ground squirrel?

The Alte Pinakothek in Munich has a large and extraordinary collection of paintings. The enormous painting by Rubens, "The Last Judgment," shows the Lord and Christ sitting on clouds looking down on the crowd of damned naked woman that try to struggle upwards from Hell, while being bitten by all kinds of monsters. It reminded me of committees instituted in some places to decide which patients in chronic renal failure may be treated with the artificial kidney and which may not be.

Berlin

We were guests of the Free University of Berlin. I gave two lectures (German) and two conferences (in German). Our host was Dr. Bücherl, Professor of Surgery. I wanted to come to Berlin to see the experimental work of his group since they have made artificial hearts for many years. Dr. Kirsch is the ingenious assistant concerned with the artificial heart work in Berlin.

(1) They have a Teflon that can be sprayed on latex so that the surface properties of Teflon are combined with the elasticity of rubber.

(2) They have made interesting air driven, very light artificial hearts that fit inside the chest of dogs.

(3) They have also built an epoxy–rubber pump that fits so well in the dog's chest, between the lobes of the left lung, that it can be used as an auxiliary left ventricle. The blood is taken from the left atrium and pumped into the aorta.

In the beginning they lost their animals from a hemorrhagic diathesis, which was due to excess of fibrinolytic activity. They now use E (epsilon) aminocaproic acid which is an antifibrinolytic agent. Prof. Bücherl uses this routinely in all his open heart cases. The hemorrhagic diathesis sometimes seen after extracorporeal circulation has not been seen in Berlin since the use of their E aminocaproic acid. They give 0.1 Gm/Kg every two hours. If started early this dose suffices. However, if you give it late when the fibrinogen is already low, then you have to give 20 times as much. It is nontoxic and inexpensive, in contrast to Trosylal that is no better, but is very expensive. When you are scientifically inclined, then you can determine the need by making a thromboelastogram. We will at once try the use of antifibrinolytic agents in our calves sustained with artificial hearts inside the chest.

Various methods now recommended for treatment of hemorrhagic shock have been reinvestigated by Bücherl using standardized techniques. Results of groups of ten dogs each were compared. When used alone, transfusion with double the amount of blood lost or hyperbaric O_2 treatment, each save two or three of the ten dogs. Treatment of acidosis, pressor agents, depressor agents, digitalis, antibiotics, et cetera may prolong life but do not influence ultimate survival. Combination of blood (double dose of what is lost) and hyperbaric oxygen together increases the number of survivors to 8 of every 10 dogs.

Lung specialists will be pleased to know that Dr. Bücherl and another associate, Dr. Masseri, have homotransplanted 150 lungs in dogs. In the entire series only one dog was lost postoperatively. The technical problems are therefore solved. The function of the transplanted lung is good if one lung only is transplanted. It seems that at least some original lung tissue must be left to prevent atelectasis shortly following transplantation. It seems, then, that a substance normally formed by the lung, perhaps surfactant material, is not immediately formed by the transplant, although it later is.

Three dogs treated with Imuran lived longer than one year and the transplanted lung proved to be fully normal with bronchospirometry. I personally saw a black dog in good condition with a lung homotransplanted five months before. This dog had one peculiarity — he bit only ordinarius (i. e., full) professors, but no associates. These dogs are given more Imuran when their white count increases over 6,000, thus some of them get as much as 10 mg/Kg.

The clinical implication is obvious. What else can a patient with severe asthma or emphysema look forward to? What about obtaining donors? A person may request his family to donate after his death, all the internal organs that can be used, his kidneys, his liver, and his lungs, perhaps also his heart. Eyes, bones and aorta are welcome as before. Only if we give every person admitted to a hospital an option to do so will we get some of the organs that are so desperately needed.

Treatment of Septic Shock

A Progress Report

FRANK W. AMES, M.D., and MARTIN J. FISCHER, M.D.

THIS paper is a progress report on the treatment of septic shock. It will deal with two phases; fifty-eight consecutive cases of gram-negative septicemia occurring between April 1, 1963 and April 1, 1964, and a comparison with 50 consecutive cases between April 1, 1962 and April 1, 1963. Whereas the authors saw and played some role in diagnosis and management of approximately 90 per cent of the 1962-1963 series, only 69 per cent of the 1963 - 1964 group were seen. We will compare the two groups with regard to several clinical features, and then analyze the entire 108 cases concentrating on therapy, particularly on the choice and dosage of antibiotic and steroid drugs.

Clinical Features

The signs, symptoms, and laboratory results showed little change from the previous year.[1] Neither did our original impression of the three separate stages of gram-negative septicemia.[1]

There are some points we would mention concerning the portal of entry and the organisms cultured (see Tables 1 and 2). As one can see in Table 1, the urinary tract still holds a commanding lead as a portal of entry. Of interest is the increase in the number of patients with a portal of entry elsewhere than the urinary, GI-biliary, or gynecological systems. These include skin and lungs for the greater part. This indicates the increasing adaptability of gram-negative organisms and we might postulate their increased presence in other systems in future years.

TABLE 1. *Portal of Entry*

System	62-3	63-4	Total
Urinary	28	29	57
GI - biliary	11	12	23
Gynecological	6	6	12
Elsewhere	5	11	16

In Table 2 the types and numbers of organisms are listed. Of note is the marked increase in unidentifiable species. We must consider the possibility of organism mutation secondary to the marked increase in use of broad spectrum antibiotics.

There has been a continuance of little success with *Pseudomonas* septicemia. Shock has developed in all cases with over 50 per cent mortality. Over the past year there was an increase in the incidence of *Proteus* septicemia. Septic shock was universal but with adequate therapy the mortality rate has been less than 33 per cent.

The cases with sepsis from biliary portal of entry were characterized by very poor results — only 2 of 15 patients survived. Four patients died of septicemia complicating hepatic decompensation. Two were postoperative patients. Four patients died after operations on the biliary tract — three were following cholecystectomy plus common duct exploration, and one was several months post-cholecystectomy. There were four patients with biliary tract obstruction due to stone, complicated by acute cholangitis. Three were treated without operation and died. One died post-cholecystostomy. The treatment of this special situation should be appropriate antibiotics, steroids and to surgically decompress the liver. Because of edema secondary to the acute process and/or previous cholecystitis, the cystic duct will almost always be too narrowed for cholecystostomy to provide adequate

TABLE 2. *Organisms*

Organism	62-3	63-4	Total
Escherichia coli	21	18	39
Proteus	6	10	16
Pseudomonas	5	4	9
Aerobactor	3	1	4
Bacteroides	3	2	5
Klebsiella Aerobactor	3	1	4
Alkaligenes Fecalis	2		2
Hemophilus	2	1	3
Klebsiella Pseudomonas	1		1
Klebsiella	1	1	2
Paracolon (Prov.)	1	3	4
Salmonella	1	1	2
Unidentified Gram-negative bacilli	2	15	17

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biliary tract drainage, and T-tube drainage of the common duct should be performed.

There were three cases of acute cholecystitis without cholangitis. The patient treated medically died. The two treated with cholecystectomy were the only survivors of this entire biliary group. The errors most frequently encountered in this group are: (1) to undertreat with respect to drugs, (2) to delay or not surgically intervene, and (3) to perform the incorrect surgical procedure.

The authors have seen three cases of fulminant septicemia with shock occurring in the third trimester of pregnancy. None of the patients were in labor. The etiology in all was urinary tract infection, attendant upon the physiologic changes of the upper urinary tract during pregnancy. An attempt to alleviate the physiologic obstruction with ureteral catheterization was made in two. Frank pus was obtained. Both patients continued to worsen. In one, eclampsia masked shock for several hours. Emergency cesarian section was performed in both cases; both mothers and both babies survived without sequelae. The third case was successfully managed with antibiotics and steroids.

Therapy of Gram-Negative Septicemia And Shock

Correct therapy still requires early diagnosis, immediate antibiotics in adequate dosage, and restoration or maintenance of blood pressure and urinary output.

Further evidence is present that adequate antibiotic coverage is the cornerstone of treatment. In Table 3 the results and dosages of antibiotic therapy are shown. These figures represent cases where the drugs

TABLE 3. *Results of Antibiotic Therapy*

Antibiotic	Good Result	Poor Result	Dosage/24 hrs.
Penicillin	37	10	39-90 mil. units I.V.
Tetracycline+ Streptomycin	13	5	
Chloramphenicol+ Kanamycin	13	2	
Tetracycline	11	8	2 Gm., I.V.
Streptomycin	26	10	2 Gm., I.M.
Chloramphenicol	26	9	4-8 Gm., I.V.
Kanamycin	7	2	1.5-2 Gm., I.M.
Colymycin	9	3	250-300 mg., I.M.

were used in adequate dosage only and the table represents the results of 108 cases over the two year period.

Important facts which can be gleaned from this table are: (1) results are better with combinations of drugs, (2) the best combinations are penicillin with either chloramphenicol and kanamycin, chloramphenicol and streptomycin, or tetracycline and streptomycin (penicillin in combination with other drugs in adequate dosages has given good results in three out of four cases), and (3) kanamycin or colymycin may be used alone in very selected cases with good results to be expected. It is still suggested that adequate antibiotic therapy be continued at least 48 to 72 hours after control of shock, until the patient is clinically improved, afebrile (not hypothermic), has a normal blood count, and/or after three successive negative blood cultures. The authors still do not advise changing an antibiotic regimen because of conflicting sensitivity reports if the patient is doing well clinically. It is also advisable to switch combinations of antibiotics after 18 to 36 hours if the patient has not clinically responded to the initial regimen.

Treatment of Septic Shock with Steroids

When shock occurs, the authors' ideas on the use of large doses of steroids are unchanged. Despite the increase in published literature in favor of their use[2-4] and their availability in this hospital free of cost* to the patient, a disappointingly small amount of this compound was used in treating septic shock during the past year. We still advise their use intravenously or by intravenous infusion in the dosage of 80 milligrams of methylprednisolone every 6 to 8 hours up to a period of 72 hours. The drug may be stopped abruptly at this time without tapering their dosage; however if used longer than 72 hours, it is safer to gradually taper the dosage to zero to prevent adrenal decompensation.[3,5]

Vasopressor drugs are still advised with the thought in mind that they are supportive and not therapeutic agents. It is advised that they should not be used without steroids for theoretical[5,6] and practical reasons.[1,7]

Results of Treatment of Septic Shock

In the 1963-1964 group 38 of 58 patients with positive blood cultures for gram-negative organisms developed septic shock. A comparison with the 1962-1963 group and the total series may be seen in Table 4.

TABLE 4. *Results of the Treatment of Septic Shock*

	April 1962-3	April 1963-64	Total
Number of patients with positive blood cultures	50	58	108
Number of patients that developed septic shock	34	38	72
Mortality rate—shock and non-shock groups	40%	31%	35%
Mortality rate—shock group only	59%	48%	53%
Mortality rate in cases treated with adequate antibiotics	35%	50%	42%
Mortality rate in cases treated with adequate antibiotics and steroids	23%	40%	30%

There was some improvement in the mortality rate in the 1963-1964 group but as you can see the overall mortality of septic shock is greater than 50 per cent.

Results of antibiotic therapy in the 1963-1964 group only strengthens the concept of their primary role in treatment of septic shock. In the 1962-1963 series, no patients survived treated with inadequate antibiotics. This year one patient survived on inade-

*Solu-Medrol® (480 vials) has been supplied by Dr. S. S. Stubbs of The Upjohn Company.

TABLE 5. *Evaluation of 72 Patients With Shock*

	Lived	Died
Inadequate antibiotics No steroids	1	21
Adequate antibiotics No steroids	11	7
Adequate antibiotics Inadequate steroids	2	7
Adequate antibiotics Adequate steroids	16	7

quate antibiotics but overall there have been very poor results (see Fig. 1).

Steroids in adequate dosage were used in only five patients in the last nine months of the 1963-1964 group. Three of these patients received steroids in

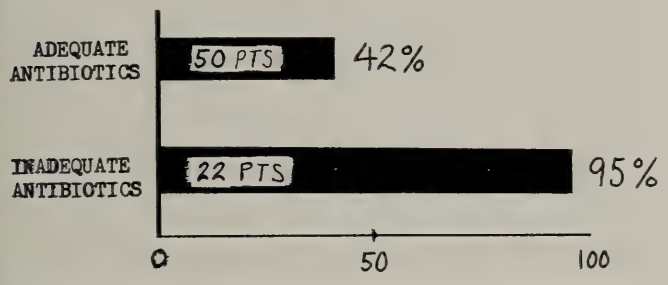


FIG. 1. *Mortality Related to Antibiotic Therapy*

inadequate amounts. No conclusions could be drawn from this small group. However over the two year period steroids were used in adequate dosage in 23 patients and 16 of these survived. There were 49 patients who developed septic shock and had inadequate or no steroids; 35 (or 71 per cent) of these died. The difference between these two groups is statistically significant (see Fig. 2).

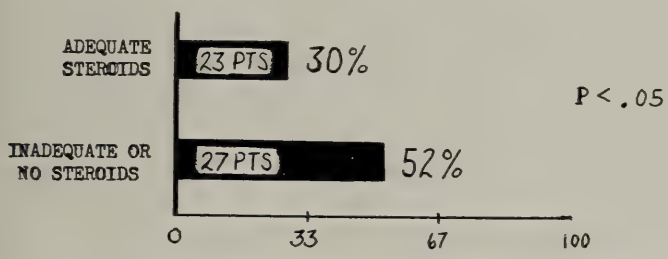


FIG. 2. *Mortality Related to Steroid Therapy. (These patients all had adequate antibiotic therapy.)*

From these figures we can surely conclude that treatment of septic shock with adequate antibiotics and steroids is of utmost importance in promoting patient survival. With early diagnosis and immediate therapy good results can be expected in a majority of cases.

Summary

1. Fifty-eight patients with gram-negative septicemia and septic shock occurring from April 1, 1963 to April 1, 1964 are compared with 50 patients from April 1, 1962 to April 1, 1963, and the overall group is reviewed.

2. The urinary tract remains the leading portal of entry, but skin and lungs showed a substantial increase.

3. Notable changes in the organisms cultured are an increase in *Proteus* species and a marked increase in unidentifiable genera of gram-negative bacilli.

4. An increasing incidence and poor outcome of biliary tract sepsis is recorded. Well timed appropriate surgery is stressed in the therapy of these problems.

5. Massive antibiotic therapy is still urged. The most effective combination found useful by the authors is penicillin, chloramphenicol and kanamycin.

6. Adrenal corticosteroids are recommended for all cases in which shock is present. A statistically significant improvement in mortality resulted from their use in pharmacologic dosage in this series.

Acknowledgment: The authors acknowledge the cooperation of the Attending Staff of Akron General Hospital in making their patients available for this study.

We wish to thank Dr. Jack Mostow for his encouragement and assistance in preparing this paper. We further thank Mr. D. Souders and the Bacteriology Department of Akron General Hospital for their cooperation in this study.

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CONTACT LENSES.— In a survey of ophthalmologist members of the Flying Physicians Association, the general feeling was that the pilot should have proven himself to be a successful wearer for 3 to 6 months prior to using them for flying. There is some indication that perhaps liberalization of the FAA regulations regarding the use of contact lenses is in order. — David C. Boyce, M. D., Grand Rapids, Mich.: *Southern Medical Journal*, 59:61-63, January, 1966.

Adverse Reactions To Drugs

Report Them to New AMA Registry!

A REGISTRY ON ADVERSE REACTIONS has been established by the Council on Drugs of the AMA. The Council has prepared several mailing pieces relating to this subject, and the following material has been extracted from one of those pieces:

* * *

The following reaction chart has been compiled from suspected cases reported to the Registry on Adverse Reactions. In addition we have included data culled from current literature. The list is necessarily limited, and further information is available upon request. *It must be stressed that this is not a condemnation of any particular drug or chemical.* Rather, it is a means of alerting the physician to the potential of drug or chemical reaction. It may serve also as a reminder in differential diagnosis when drugs or chemicals often are overlooked.

Aplastic Anemia

Benzene & other organic solvents
Chloramphenicol
Diphenylhydantoin
Insecticides
Mephenytoin
Sulfonamides
Trimethadione

Auditory Dysfunction

Chloroquine
Kanamycin
Quinine
Streptomycin
Viomycin

Collagen Disorders

Diphenylhydantoin
Griseofulvin
Hydralazine
Isoniazid
Sulfonamides

Jaundice (Cholestatic)

Aminosalicylic Acid (PAS)
Chlorpropamide
Ectylurea
Erythromycin Estolate
Imipramine
Methimazole
Methyltestosterone
Norethindrone
Norethynodrel
Phenothiazines
Triacetyloleandomycin

Jaundice (Hepatocellular)

Aminosalicylic Acid
Diphenylhydantoin
Halothane
Iproniazid & Other Hydrazines
MAO Inhibitors

Leukopenia

Chloramphenicol
Chlorothiazide
Chlorpropamide
Diphenylhydantoin
Dipyrone
Imipramine
Penicillamine
Phenothiazines
Phenylbutazone
Sulfonamides

Parkinsonism

Imipramine
Mecamylamine
Phenothiazines
Rauwolfia Alkaloids

Peripheral Neuropathy

Colistimethate Sodium
Ethionamide
Ethoxzolamide
Furaltadone
Isoniazid
Methimazole
Nitrofurantoin
Nitrofurazone
Streptomycin
Sulfonamides

Photosensitivity

Chlorothiazide
Griseofulvin
Nalidixic Acid
Phenothiazines
Sulfonamides
Tetracyclines

Psychoses

Carbarsone
Chloroquine
Isoniazid
Quinacrine
Sulfonamides

Toxic Nephropathy

Colistimethate Sodium
Kanamycin
Phenacetin
Phenindione
Phenylbutazone
Probenecid
Salicylates
Tetracyclines

* * *

This is another of the outstanding services rendered by the AMA to the public through practicing physicians. From time to time, we hope to publish additional information from this source. Physicians are encouraged to report unpublished data on serious, unusual, or unexpected reactions, even though such observations may be based only on suspicion or circumstantial evidence.

Additional information and report forms are available from the AMA Registry on Adverse Reactions, Council on Drugs, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

— THE EDITOR

Demethylchlortetracycline Overdosage

A Case Report of Toxic Effects in a Patient with Impaired Renal Function

ARMAND MANDEL, M. D.

DEMETHYLCHLORTETRACYCLINE* is the most recent of the tetracycline compounds to be isolated.[1] Since the discovery of chlortetracycline in 1948 by Duggar,[2] and the subsequent isolation of its analogues, these antibiotics have proved extremely valuable in clinical practice because of their wide range of antibacterial activity. Most gram-positive and gram-negative bacteria, the rickettsiae, and some of the large viruses are susceptible to their action. The tetracyclines are among the safest antibiotics in clinical use and serious adverse reactions are rare. The case presented has certain features which might be considered evidence of the toxicity of demethylchlortetracycline (DMCT) when given in excessive doses to a patient with impaired renal function.

Report of a Case

A 40 year old white man was admitted to the hospital 40 hours after the onset of the present illness. He had consulted a physician a few hours after the onset, with the complaint that he had awakened with chills and fever and had felt unable to continue with his work. His physician had diagnosed pneumonia and prescribed DMCT. The patient had returned home and slept almost continuously for 34 hours, waking only to take DMCT in doses of 450 mg. every four to six hours. The total dosage taken was 2400 to 2700 mg. in about 36 hours. No explanation could be obtained for the administration of this high dosage. No urine had been passed in the 20 hours prior to admission.

The previous medical history was relevant in that the patient admitted a heavy consumption of alcohol for a period of 10 years, although there had been total abstinence for the four years prior to the present illness. There was no history of liver or renal disease. The patient maintained an unusually busy work schedule, arising at 3:30 A. M. and working for about 20 hours a day almost every day of the week. He took dextropropoxyphene hydrochloride (Darvon®) in doses up to 160 mg. daily, and secobarbital occasionally. He used isoproterenol hydrochloride as a nebulizer.

On admission the patient was asleep and could be roused only with difficulty. When aroused he was well oriented, but was unable to stay awake while the history was being taken, and fell asleep even during funduscopic examination. The only other significant finding on examination was a slightly elevated blood pressure of 158/102. The pulse and temperature were normal, the lungs clear, the heart sounds physiological and the abdomen soft and free of tenderness or palpable masses. Neurologic examination revealed no evidence of a focal cerebral lesion or of meningeal irritation.

The patient was catheterized and 450 ml. of dark amber urine was obtained. Urinalysis showed a specific gravity of 1.018 and 3 plus proteinuria. On microscopic examination there were 1 to 2 red blood cells and 1 to 2 granular casts per high power field. The blood urea nitrogen was moderately elevated (Table 1).

Intravenous infusions were given because the patient was too drowsy to take fluids orally. In the first 24 hours he developed puffiness of the face and periorbital edema, and there was a weight gain of 8 lb. Oliguria persisted during the first four hospital days. On the second day the blood chemistries revealed a rising blood urea nitrogen (BUN) and marked abnormalities of serum glutamic oxalacetic transaminase (SGOT) and serum glutamic pyruvic transaminase (SGPT). The SGPT was so high that it could not be determined in a 1:20 serum dilution. At this time, the serum antistreptolysin titer was found to be 150 units. From the third day on, there was a gradual decline in the SGOT and SGPT levels, but the BUN continued to rise until the ninth day and there was marked elevation of the serum creatinine and uric acid levels. The serum potassium levels remained within the upper limits of normal (Table 1). Daily urinalyses showed a persistently low specific gravity, traces of proteinuria, microscopic hematuria, and occasional granular casts.

The urinary output increased gradually after the fourth hospital day, and the patient then began to recover. Nineteen days after admission the BUN was still slightly elevated but the serum transaminase levels were normal. The blood pressure remained moderately elevated throughout the hospital course. There was no icterus or hepatomegaly at any time, but on one occasion there was tenderness on palpation of the right upper quadrant of the abdomen.

In view of the excessive dosage of DMCT, samples of blood were assayed for DMCT activity by the agar diffusion method, using *Bacillus cereus* as the test organism.† The first specimen, obtained about 12 hours after the last dose of DMCT, contained 6.24 μg/ml and the second speci-

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Submitted July 15, 1965.

*Declomycin® (demethylchlortetracycline) is the registered trademark of Lederle Laboratories, a Division of American Cyanamid Company, Pearl River, New York.

Reprint requests to 6681 Ridge Road, Parma, Ohio 44129 (Dr. Mandel.)

†Assay of both specimens was performed by Lederle Laboratories, Pearl River, New York.

TABLE 1. *Blood Chemistries During Hospitalization*

Day of Illness	3	4	5	6	7	8	9	10	11	12	13	21
BUN in mg/100 ml	36	41	56	61	80	88	77		77		56	24
NPN in mg/100 ml				125								
Creatinine in mg/100 ml				10.5	12		11		8.5		5.4	1.85
Uric Acid in mg/100 ml				11.2	13				9.2		6.7	
Potassium in mEq				3.2	3.9	4.5	4.8		5.3		4.9	
SGOT in units		1800	930	570	73	55	48		32		32	
SGPT in units		<2520	2520		960						194	43
Antistreptolysin-O titer in units		150										

men, obtained 33 hours later, contained 4.84 μg/ml of DMCT. Both specimens contained traces of barbiturates, the levels being too low for quantitative determination.

Comment

A diagnosis of glomerulonephritis was indicated by the diastolic hypertension, the elevated antistreptolysin titer and serum creatinine levels, the oliguria, and the findings on urinalysis. The absence of more than moderate azotemia could not be explained. The extreme drowsiness was probably due to physical exhaustion and barbiturates, although it is interesting to speculate on the possibility of a tetracycline induced encephalopathy. Manifestations of cerebral toxicity have been described in association with penicillin, sulfonamides, and streptomycin.[3] The unusually high serum levels of SGOT and SGPT are submitted as evidence of liver toxicity following the ingestion of excessive doses of DMCT.

The tetracyclines are widely distributed throughout the tissues. They are concentrated in the liver and excreted via the bile into the intestine, from where they are reabsorbed into the bloodstream.[4,5] They are eliminated mainly by renal glomerular filtration with apparently no tubular reabsorption.[4,6] The rate of clearance varies with each analogue, being dependent on the extent of their binding to the plasma proteins.[7] The renal clearance rate of DMCT is 43 per cent of the tetracycline clearance rate.[8] It has been shown to have a half-life 44 per cent longer than that of tetracycline *in vivo*.[6] Antibiotic activity persists for 72 to 96 hours after a single dose of DMCT, whereas none can be detected 72 hours after a single dose of chlortetracycline or tetracycline.[8] For this reason, the therapeutic dosage of DMCT is almost half the therapeutic dosage of the other tetracyclines.

In a study of 32 healthy volunteers receiving DMCT in the recommended oral dosage of 150 mg. four times daily, the average serum activity was found to be 1.49 to 1.84 μg/ml after 24 to 48 hours of therapy.[9] With intact renal function, the serum levels of the tetracycline compounds are maintained at a constant level until administration is discontinued. However, when glomerular filtration is inadequate, the serum levels continue to rise as long as the drug is being absorbed, and they fall much more slowly after therapy is stopped.[7,10] This is illustrated in the present case, in which the serum concentration of DMCT fell by about 22.4 per cent in the 33 hours after admission, whereas an average decline in serum levels of 86 per cent in 30 hours has been demonstrated in healthy individuals.[10]

The tetracyclines are known to be toxic to the liver in high concentrations. Fatty metamorphosis of the liver was found in experimental animals after large doses of tetracyclines over long periods of time,[11] and several cases of acute hepatic dysfunction have been reported in patients receiving large intravenous doses of these antibiotics during pregnancy.[12,13] It is significant that these patients were being treated for renal infections, and in two cases a decreased glomerular filtration rate was demonstrated.[12] In these cases, serum tetracycline levels of up to 63 μg/ml were associated with severe liver damage. In the present case, the serum level of 6.24 μg/ml 12 hours after the last dose of DMCT is not excessive in view of the dosage ingested. However, since the patient was not seen until the third day of his illness, it is probable that much higher serum levels were present prior to admission. Also, this patient may have been predisposed to liver damage because of his previous history of alcoholism and prolonged physical strain. The liver damage was slight and reversible, as evidenced by the lack of jaundice and the rapid return to normal serum transaminase levels. Nevertheless, the persistence of the antibiotic in the blood has been clearly demonstrated, and confirms the findings of others, that the tetracyclines should

be given in greatly reduced dosage in patients with impaired renal function.[7,14]

Summary

A case is reported of suspected acute, reversible liver toxicity following excessive oral dosage of demethylchlortetracycline in a patient with glomerulonephritis. Evidence is presented of delayed excretion of DMCT in the presence of impaired renal function.

Acknowledgment: The author wishes to express his appreciation to Dr. C. P. Masur of the Lederle Laboratories for his assistance.

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STAPES SURGERY. — The substitution of stapedectomy for stapes mobilization has greatly increased the incidence and degree of hearing restoration but has also introduced new hazards, one of which is increased possibility of introducing infection into the labyrinth. Because the surgeon's fingers must contact the potentially contaminated skin of the ear throughout the operation, the authors have long adhered to the following rules: perform no surgery in the presence of latent or recent active infection, sterilize the skin by a multiple preparation over 24 hours, use meticulous sterile technique, place the patient on a broad spectrum antibiotic for one day before and seven days after operation, and continue the sterile technique in postoperative care. Because of their findings in the studies reported here, they now use Ioprep® (a new iodine antiseptic agent) rather than hexachlorophene for sterilizing the ear canal. The most effective antibiotic for pre- and postoperative use was found to be tetracycline plus sodium novobiocin (Panalba®). Furthermore, because organisms present in the ear canal tend to be carried into the middle ear by the surgeon's instruments, they now discard any material, such as absorbable gelatin sponge (Gelfoam®), that has accidentally touched the ear canal while being introduced into the open oval window. The authors also studied the possibility that the postoperative sensorineural loss that all surgeons note to some degree might be due to subclinical infection of the labyrinth; no correlation was found between presence of a positive culture during surgery and the incidence of sensorineural loss, but a fairly large statistical population would be required to rule out such a correlation.— ABSTRACT: William K. Wright, M. D., Houston, and Paul J. Marmesh, M. D., San Antonio, Texas: *Archives of Otolaryngology,* 81:566-569 (June) 1965.

Apnea Due To Intramuscular Colistin Therapy

Report of a Case

MICHAEL A. ANTHONY, M.D., and DAVID L. LOUIS, M.D.

NONFATAL apnea due to colistin therapy was recently reported by Perkins.[1] In discussing the toxicity of this drug, Fekety, Norman, and Cluff refer to transient apnea in an elderly patient receiving colistin.[2] The patient reported by Perkins was also receiving corticosteroids during the period of treatment with sodium colistin. The patient referred to by Fekety had undergone a surgical procedure and in the early postoperative period became apneic for several hours. Thiopental sodium, nitrous oxide, bromochlorotrifluoroethane, and succinylcholine had been used as anesthetic agents. Both authors point out that drugs other than colistin could not be excluded as factors in the development of the apnea.

The present report is concerned with the occurrence of apnea in a woman with chronic renal disease, who became symptomatic following therapy with colistin and methenamine mandelate. The toxicity of methenamine mandelate is related to the systemic acidosis which it may cause if not adequately excreted. Since the patient had received only 1 gram of this drug at the time the initial symptoms developed, it is unlikely that the methenamine mandelate was a factor in her course.

Case Report

The patient was a 47 year old female Cuban refugee who was admitted April 2, 1964, for the evaluation and treatment of chills, fever, and hematuria.

She had had surgical removal of renal calculi four years prior to admission, while still living in Cuba. On follow-up evaluation prior to leaving for the United States, she was informed that the calculi had reformed. She had remained asymptomatic, however, until three weeks prior to admission, when she began to experience evening fever with associated chilling. She also began passing "dark" urine.

The physical examination revealed a swarthy, hyperactive, normally developed woman, who was not in acute distress and did not appear chronically ill. The blood pressure was 150/100 mm. Hg, the cardiac rate was 110 with a regular rhythm, and the temperature was 99.4° F. The only significant abnormality on physical examination was the presence of an easily palpable, nontender right kidney.

The admission hemogram revealed a hemoglobin level of 8.6 Gm. per 100 ml. and a hematocrit of 26 per cent. The white blood cell count was 6,640 with 73 per cent segmented neutrophils, 10 per cent lymphocytes, 9 per cent band cells, and 2 per cent monocytes. The urinalysis revealed a specific gravity of 1.007 and a ph of 7.0 and contained 100 mg. per 100 ml. of albumin. Examination of the urinary sediment revealed 20 to 30 white blood cells and many red blood cells per high power field. The blood urea nitrogen was 31 mg. per 100 ml., the creatinine was 2.7 mg. per 100 ml., the serum calcium was 4.5 mg. per 100 ml., and the serum phosphorus was 5.0 mg. per 100 ml. The urine culture on admission was positive for *Proteus mirabilis.*

X-ray films of the chest revealed the heart, mediastinum, lung fields, bony thorax, and diaphragm to be without abnormality. The scout film of the abdomen revealed an "almost complete cast of the calyceal internal collecting system of both kidneys because of multiple confluent staghorn calculi." Following injection of contrast material, there was no visible concentration of the material in either kidney.

The patient received two units of whole blood on the two days following admission. While receiving the second transfusion the patient's temperature rose to 102°F., and she experienced a chill. The transfusion was discontinued, and there was no laboratory evidence of hemolysis.

Six days following admission cystoscopy and retrograde studies were carried out. Following injection of indigotin disulfonate, the dye appeared in nine minutes on the right but none was observed from the left. Cultures of the bladder and kidney urine were positive for *P mirabilis.* There were 100,000 bacteria per ml. from the culture of the bladder urine, 50,000 per ml. from the right kidney and 15,000 bacteria per ml. from the culture of urine of the left kidney.

The hemoglobin level one week after admission was 10.6 Gm. The white blood cell count was 7,770 with a left shift. The urinalysis revealed a specific gravity of 1.007 with many red and white blood cells in the urinary sediment. Two weeks after admission the hemoglobin level was 9.7 Gm. The blood urea nitrogen at this time was 43 mg. per 100 ml., and the creatinine was 2.7 mg. per 100 ml. A week later the blood urea nitrogen was 66 mg. per 100 ml. and the creatinine was 3.9 mg. per 100 ml. Serum sodium, potassium, and chloride were normal. Repeated urinalyses were positive for red and white blood cells.

Operation: It was the opinion of the physicians attending the patient that the removal of the calculi in the functioning right kidney was indicated, in an attempt to decrease infection and preserve remaining function. Three weeks after admission, the necessary surgical procedure was performed. Stones were palpable in most of the calyces. The lower pole was opened, and approximately 30 cc. of creamy purulent material was removed. Several calyces were

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Submitted June 22, 1965.

opened and small stones were removed. Two large staghorn calculi were removed from an incision in the upper pole of the kidney. A mushroom catheter was left in place.

The patient's course was one of slow but progressive improvement during the three weeks following surgery and she had only minor elevations of temperature. During this period the hemoglobin level fluctuated between 10 and 11 grams and the white blood cell count was constantly below 10,000, with some left shift. The blood urea nitrogen levels drawn every other day during this period varied between 50 and 60 mg. per 100 ml. and creatinine gradually decreased from a high of 4.1 to a low of 1.7 mg. per 100 ml. Urinalyses during this period were all strongly positive for red and white blood cells.

Four weeks after the surgical procedure, the patient developed a fever of 103°F., and the urine culture was again positive for *P mirabilis.* The infection was treated with methenamine mandelate and nitrofurantoin, and the temperature returned to normal within four days.

The patient again improved clinically and was afebrile over the next three weeks. The urine cytology remained strongly positive. The blood urea nitrogen slowly dropped to a level of 21 mg. per 100 ml. and the creatinine to a level of 1.5 mg. per 100 ml. The urine cultures remained positive for *P mirabilis.* The hemoglobin level varied between 8.5 and 9.5 grams during this period.

Two months after the surgical procedure, the temperature again elevated to 104°F., and the nephrostomy site was found to be infected. The blood urea nitrogen rose to between 40 and 50 mg. per 100 ml. but returned to 20 mg. per 100 ml. within a week.

Three months following admission a nephrostomy was successfully performed for the removal of additional calculi, and a nephrostomy tube was placed. The microscopic report of the biopsy section was as follows:

The sections of soft tissue include portions of kidney and fibroadipose tissue. The kidney shows an area of extensive scarring with heavy lymphocytic infiltration and focal deposition of blue staining marrow salts. The fibroadipose tissue is heavily infiltrated with acute and chronic inflammatory cells.

The findings were reported as being consistent with chronic pyelonephritis. An analysis of the stones removed at surgery revealed them to consist of calcium and ammonium phosphates. A urine culture on the day of surgery grew 25,000 colonies per ml. of *Escherichia coli.* The blood urea nitrogen level on the first postoperative day was 43 mg. per 100 ml. but this gradually dropped to 24 mg. per 100 ml. over the next two weeks.

During the last week in August, the patient's blood urea nitrogen again began to rise to levels of between 40 and 50 mg. per 100 ml. Following the elevation of the blood urea nitrogen the intake of solid food decreased but her intake of liquids remained good and her urine output was at least 1000 cc. daily.

On September 27 the urine culture was reported positive for *Pseudomonas,* and she was placed in isolation. (In spite of assurances on the part of the staff and her countrymen that isolation was routine for all patients with a pseudomonas infection, the patient could not accept that she did not have some terrible disease about which information was being withheld from her. As a consequence, she became severely depressed.)

On September 28, 1964, colistin therapy was started and was to be given as 100 mg. intramuscularly three times daily. She was also to be given methenamine mandelate, 1.0 gram, four times daily. Nitrofurantoin, which she had been receiving as 50 mg. three times daily for approximately four weeks, was stopped at the time the colistin-mandelate combination was started. The nurses' notes indicate that the patient was doing well and taking liquids well on the date the colistin therapy was started. About eight hours after the initial injection of colistin, she became quite restless and was given 25 mg. of meperidine and 25 mg. of promethazine hydrochloride. Several hours later she complained of numbness about the mouth, and she refused the morning injection of colistin because she felt it caused the numbness about the mouth. She received all subsequent injections of the drug.

After the noon injection of the medication the patient then developed a sensation of numbness in the hands in addition to the paresthesia about the mouth. She also complained of feeling weak. These symptoms were attributed to anxiety, and she was again treated with meperidine and promethazine hydrochloride. The sensation of numbness persisted throughout the day and in the late afternoon while sitting in a chair she was noted to be "ashen." The vital signs at this time revealed the blood pressure to be 130/80, the pulse rate was 108 per minute and was regular, the respirations were 20 per minute, and the temperature was 98°. The symptoms regressed and she was described as having a "better evening." Shortly after midnight on September 30, she was observed to be restless and uncomfortable and was again treated with meperidine and promethazine hydrochloride. At 3:00 A. M. on September 30 she was again given meperidine and promethazine hydrochloride for restlessness.

At 11:00 A. M. on September 30 the patient was unable to walk unassisted because of intense weakness, ataxia, and lightheadedness. These symptoms were intermittently present throughout the day. She slept fitfully during the night and had several episodes of nausea with small amounts of emesis. On the morning of October 1 she complained of itching of the face, hands, and arms. There was no visible rash. Two hours after the onset of the itching, she was very unsteady when on her feet. She was nauseated and refused to take any liquid. The nausea persisted throughout the day, and she refused to leave her bed because of the difficulty walking. She was again extremely restless during the night, requiring meperidine and promethazine hydrochloride several times. At 11:00 A. M. on October 2 the patient complained of shortness of breath, and oxygen was started by nasal cannula. In addition, she was given 50 mg. of hydroxyzine. At 2:00 P. M. her respirations were noted to be irregular, her blood pressure was 130/80, and her pulse was 110 with regular rhythm. She was also noted to have "twitching" of the hands and feet. At 2:40 P. M. she became completely apneic. She was given an injection of ethamivan and mouth-to-mouth breathing was instituted until the respirator could be obtained.

When the authors were asked to see the patient at 3:00 P. M. the respirator was removed and the respirations were noted to be feeble, shallow, and irregular with little thoracic expansion and very little air exchange. She was aware of her surroundings but was not completely lucid and could speak only with difficulty. Mechanical respiration was again instituted until a tracheostomy could be performed. At this time the blood pressure was 140/110 and the pulse rate was 120 with a regular rhythm. Within 15 minutes after the tracheostomy and with the respirator operating, she became alert and responsive, but there was no spontaneous respiration. At 6:00 P. M. the respirator was discontinued for approximately 10 minutes. The patient breathed spontaneously, regularly, and effectively for approximately five minutes. During the next five minutes the respiratory exchange was adequate, although the respiratory rhythm was quite irregular. The patient became quite restless and anxious and requested that the respirator again be started.

The vital signs remained stable until 11:00 P. M. on October 2. At that time the blood pressure began to drop and she was given an ampule of glucaheptonate sterile solution, in addition to an intravenous infusion containing noradrenalin. In spite of the noradrenalin and hydrocortisone given intravenously the blood pressure continued to drop and the patient died on October 3 at 1:25 A. M. The cardiac rhythm was noted to be irregular at about 12:45 A. M. on October 3 and an electrocardiogram at that time revealed a slow and irregular idioventricular rhythm.

Throughout her illness the patient's carbon dioxide combining power had been above 20 mEq per liter. Her serum sodium had been in the range of 130 to 140 mEq/liter, and her serum potassium had been constantly below 4.5 mEq/liter. On the 2nd of October the carbon dioxide combining power was found to be 11.1 mEq., the serum sodium 118 mEq., and the serum potassium 5.1 mEq/liter. The carbon dioxide combining power and potassium drawn after the blood pressure began to fall on October 2nd, were reported as 14.7 mEq/liter and 6.7 mEq/liter respectively.

An autopsy was performed on the morning of her death. The heart was not enlarged. The myocardium was noted to be flabby and reddish brown in color. The microscopical sections of the myocardium revealed large numbers of neu-

trophils scattered loosely through the connective tissue of the myocardium. The microscopic section of the lungs revealed severe pulmonary edema with considerable precipitated eosinophilic material filling the alveoli. The right kidney was tightly bound to the lateral and posterior walls of the abdomen by very tough fibrous adhesions, which followed along the nephrostomy wound to the subcutaneous tissue of the skin. The kidneys revealed very marked hydronephrosis and dilated calyces and pelves were filled with a very thick greenish pus. There was a considerable amount of sandy material mixed with the pus and in both kidneys there were fragments of stones. There was one large stone, 2 cm. in length, in each kidney. Together the kidneys weighed 276 Gm., but this weight included a considerable amount of pericaliceal and peripelvic fatty and scar tissue. The mucosa of the calices and pelves of both kidneys was intensely hyperemic and granular. Histologic studies of the kidney fragments revealed extensive, acute and chronic inflammatory exudate throughout all sections of the kidneys with considerable fibrosis and destruction of renal architecture. The tubules were filled with hyaline casts and clumps of neutrophils. There was ulceration of the caliceal mucosa. There was moderately severe vascular sclerosis.

Discussion

Colistin is a basic polypeptide closely resembling polymyxin B in configuration except for the absence of phenylalanine in its molecular structure. An oral preparation, colistin sulfate, and an intramuscular preparation, sodium colistin, are available. Petersdorf et al. are of the opinion that the daily dose of the drug in the adult should be no less than 300 mg. even at the risk of toxicity.[3]

Colistin has been shown to be effective in the treatment of infections caused by *E. coli, Hemophilus, Aerobacter, Klebsiella, Shigella,* and *Salmonella*[2,3] and it would appear that colistin is the drug of choice in deep-seated *Pseudomonas* infection.[3]

Initial studies reported colistin to be free of serious toxicity. These studies were based on the reactions of patients receiving lower dosages than presently recommended. With the use of higher dosages the incidence of toxicity due to colistin may be as high as 50 per cent. The toxic effects of the drug are reflected in disturbances of renal and neurologic function.

The impairment of renal function usually manifests as a rise in blood urea nitrogen. In the study of Fekety[2] no patient with good renal function developed evidence of nephrotoxicity. He did not feel that azotemia represented a contraindication to the use of colistin and did, in fact, successfully treat two patients with acute renal failure. Atuk, Mosca, and Kunin described the use of colistin in modified dosage in patients with uremia. These patients did not exhibit evidence of nephrotoxicity with the reduced dosage schedule.[4]

The neurologic manifestations of toxicity apparently result from the neuromuscular blocking properties which colistin shares with other clinically important polypeptide antibiotics.[5-7] The clinical manifestations of toxicity due to colistin have been well documented and include paresthesia, pruritis, ataxia, nystagmus, nausea, fever, and hallucinations. The paresthesia is most prominent about the mouth but it may also involve the extremities as it did in this patient. It may be that restlessness can also be considered a manifestation of toxicity, since this complaint had not been a problem in our patient until onset of colistin therapy. The incidence of the development of toxicity due to colistin therapy may be as high as 50 per cent with the highest incidence occurring in those patients with impaired renal function.

The patient discussed in this report developed symptoms of toxicity within 10 to 12 hours after the initial injection of the drug. Previous reports do not describe the onset of symptoms of toxicity so soon after the initial injection. This would agree with previous suggestions that the rapidity of onset of symptoms in the susceptible patient is a function of the ability of the kidney to clear the drug.

In the management of the severely ill patient it is difficult to incriminate a single medication or event which alone causes death or is directly contributory. The sequence of events leading to the death of this patient is so typically that previously described in those patients receiving colistin that the authors felt an obligation to report the problem.

Previous reports indicate that colistin is an effective antimicrobial agent and its use should not be contraindicated so long as the user is aware of the potentially serious side effects of the drug, particularly in those patients with impaired renal function.

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ATTENTION PROGRAM CHAIRMEN: We are most anxious to receive for consideration manuscripts, abstracts, or news items based upon lectures, symposia, etc., presented to Ohio physicians or those presented by Ohio physicians to other groups. — THE EDITOR.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

COLIN R. MACPHERSON, M. D., *President*

PRESENTATION OF CASE

FIRST ADMISSION: A 32 year old woman was admitted to University Hospital because of swollen, painful feet and legs for several weeks. Three years prior to admission the patient began to drink considerable ethanol and after six months of heavy drinking she developed ascites and swelling of the feet. She also noted palpitations, dyspnea on exertion, increasing fatigability, and pain and tenderness in both thighs. The patient denied any history of hepatitis, hematemesis, melena, abdominal or chest pain. The past history and the review of systems were noncontributory.

Physical examination revealed a moderately well developed white woman in moderate acute distress, complaining of pain in the thighs. The blood pressure was 128/90, the pulse rate 104 per minute and regular, respiratory rate 28 per minute, and temperature 100.4°F orally. Examination of the skin revealed palmar erythema and scattered spider nevi. The neck veins were not distended. The lungs were clear to percussion and auscultation. Examination of the heart revealed a regular tachycardia and no apparent cardiomegaly. The second sound was split, and one examiner noted a soft, short, Grade I/VI systolic ejection murmur along the left sternal border. The abdomen was enlarged with obvious ascites. The liver was palpable 10 cm. below the right costal margin and was tender. The spleen was palpable 3-4 cm. below the left costal margin. Two to 3 plus pitting edema was present in both lower extremities but was slightly greater on the right with some increased warmth in the right leg. Homans' sign was negative bilaterally. Tenderness to palpation was noted in both femoral triangles. No abnormalities were described in the neurologic examination.

The admission laboratory studies revealed a normal white blood cell count, a hemoglobin of 12.1 Gm., and a hematocrit of 35 per cent. The urinalysis, the blood urea nitrogen, creatinine, and blood sugar were within normal limits. The bilirubin was 1.1 mg./100 ml., prothrombin time 51 per cent; cephalin flocculation 3 plus, thymol turbidity greater than 100; bromsulphalein retention 28 per cent; cholesterol 84 mg./100 ml.; alkaline phosphatase 10.9 units; serum glutamic oxalacetic transaminase 89 units; lactic dehydrogenase 250 units; total protein 9.7 Gm/100 ml. (albumin 3.5, globulin 6.2), and a diffuse homogeneous increase in gamma globulin on paper electrophoresis. The serum sodium was 132, potassium 4.7, chloride 108, and CO_2 28 mEq./liter.

The chest x-ray revealed diffuse cardiomegaly and no active lung disease. The upper gastrointestinal film was reported as normal. The electrocardiogram revealed right axis deviation, incomplete right bundle branch block, and nonspecific ST and T wave changes.

The treatment consisted of bed rest, heat and elevation of the legs, low sodium diet, diuretics, and heparin. The patient lost 22 lbs. and noted considerable improvement in the pain and tenderness of her thighs. The pathological report of the liver biopsy was, "Focal fibrosis and chronic inflammation." The patient was discharged markedly improved after 12 days in the hospital, on chlorothiazide, Aldactone® and low sodium diet.

Second Admission

The patient was readmitted three months later with a five-day history of chills, fever, and marked shortness of breath, and two days prior to admission she developed vomiting and diarrhea. Since her discharge the patient had noted moderate recurrent swelling of her abdomen, legs and feet. She had noted marked dyspnea on exertion with shortness of breath at rest and two-pillow orthopnea but had had no episodes of paroxysmal nocturnal dyspnea.

The physical examination revealed an acutely ill white woman who was lethargic and confused. The

Presented by

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- **Emmerich von Haam, M. D., Columbus;**

Edited by Dr. von Haam.

Submitted January 17, 1966.

blood pressure was 80/50, the pulse rate 105 per minute and regular, respiratory rate 20/min., and temperature 103° rectally. The neck veins were markedly distended with prominent A waves. Scattered inspiratory rales were heard throughout the lung fields. Examination of the heart revealed a regular tachycardia. The point of maximum impulse was 3 cm. outside the midclavicular line; a definite parasternal lift was present. A Grade II/VI rumbling middiastolic murmur without opening snap was heard at the apex. Slightly increased splitting of the second sound was noted with a definite increase in the pulmonary component. Several examiners described a right ventricular gallop. Ascites was present, and the liver was palpable 10 cm. below the right costal margin and was tender. The spleen was palpable 3 cm. below the left costal margin. Two plus pitting pretibial edema was noted. No signs of phlebitis, clubbing of the fingers, or cyanosis were present. Neurologic examination revealed only lethargy and confusion.

Laboratory studies revealed a hemoglobin of 11.4 Gm., a hematocrit of 36 per cent and a white blood cell count of 12,000 with a normal differential count. The urinalysis showed 320 mg. of protein per 100 ml. Serum electrolyte determinations revealed a sodium of 120, a potassium of 6.0, chlorides of 95, and a CO_2 of 12 mEq./liter. The serum bilirubin was 0.8 mg. The prothrombin time was 18.9 per cent. Serum proteins again revealed a reversal of the albumin/globulin ratio with a diffuse increase in gamma globulin on electrophoresis. Cultures of the urine, spinal fluid, blood, sputum, and vagina revealed no pathogens. Blood gas studies revealed a pH of 7.2; pCO_2 of 20.1 mm. Hg.; O_2 saturation 96.2 per cent (patient on nasal oxygen at time of determination). She had a red blood cell volume of 1,950 ml. (theoretical 1,775 ml.), a plasma volume of 3,625 ml. (theoretical 2,425 ml.), and the total blood volume was 5,575 ml. (theoretical 4,200 ml.).

Posterior-anterior and left lateral chest films showed cardiomegaly without specific chamber enlargement and a prominent pulmonary artery. The electrocardiogram revealed a wide P wave in leads II, III, AVF, and a right intraventricular conduction defect.

The patient presented multiple problems consisting of severe hypotension, oliguria, electrolyte imbalance, sepsis, and congestive heart failure. She was initially started on treatment with chloromycetin and penicillin for possible sepsis, and Aramine® was started to maintain her blood pressure. Phlebotomy was done with some improvement in her dyspnea. Digitalis therapy and fluid restriction were initiated.

Because of increasing azotemia and severe electrolyte imbalance, peritoneal dialysis was begun on the third hospital day and after 20 exchanges the electrolyte abnormalities had corrected and 5 liters of excess fluid had been removed. On the second and fifth hospital days the patient had episodes of hemoptysis although chest x-rays revealed no change. After the peritoneal dialysis the patient's renal function improved with increased output of urine and drop in creatinine and blood urea. However, she continued to be febrile and hypotensive and finally required Levophed® to maintain blood pressure. Corticosteroid therapy was started in an attempt to help stabilize her blood pressure. On the eighth hospital day the patient developed ventricular tachycardia followed by cardiac arrest on the ninth hospital day.

CLINICAL DISCUSSION

DR. WEISSLER: To begin with, I find that this is a very difficult case in that throughout this protocol we are unable to detect any specific signs of the disease that killed this patient, and I really wonder whether Dr. von Haam will be able to tell us why she died.

Our patient was a 32 year old alcoholic female who entered the hospital with signs of cirrhosis and portal hypertension. She had in addition pain in the thighs which was unexplained throughout her hospital course. Although the clinicians realized that she had cirrhosis with portal hypertension, and her cholesterol means rather severe liver disease, one can detect certain important misconceptions concerning her heart disease. We are told that there was no apparent cardiomegaly and that her neck veins were not distended, yet we are told also that she had cardiomegaly on her chest x-ray. On her x-rays, it's quite apparent that this patient had a distended superior vena cava at the time of her first admission. Her electrocardiogram suggested right atrial disease. Despite these clues her heart disease was not pursued on her first admission. She diuresed, improved, and was discharged.

After three months she came back with acute dyspnea and a recent febrile illness with chills, vomiting, and diarrhea. On physical examination she had tachycardia and hypotension. Her neck veins were noted to be markedly distended, and there was a large A-wave. She had cardiomegaly and a diastolic rumble without an opening snap. She presented clearly signs of pulmonary hypertension. She had a right ventricular gallop and signs of portal hypertension with splenomegaly as well as hepatomegaly. There are several complicating factors that became clearly apparent before this patient died. She had proteinuria and acidosis with uremia. We really have very poor evidence of the nature of any renal disease that might have caused these, and apparently her urine did not reflect anything dramatic other than the proteinuria.

Her doctors were most impressed with the fact that this woman had sepsis and they looked for bacteria and were unable to find them in the numerous places from which cultures were taken. There was no apparent decrease in her red blood cell or plasma

volume, and we cannot explain her hypotension by any blood loss or diminution in blood volume. Her final hospital course was characterized by persisting hypotension, oliguria, congestive heart failure, sepsis. She became acutely uremic and a peritoneal dialysis was done with quite good improvement of her uremia and electrolyte imbalance. Prior to her death she developed hemoptysis followed by ventricular tachycardia and cardiac arrest.

I have searched through the protocol and really have found no consistent theme that I could use for a definite diagnosis. I could suspect many disease processes but I am unable to pick out one that consistently runs through the entire protocol. So I would like at this time to turn to the two kinds of information on which the cardiologist must rely when he is not at the bedside of the patient — the EKG and the x-ray. I think we can say from her EKG that she had right atrial hypertrophy and probably right ventricular hypertrophy. So we have a woman who came in initially with liver cirrhosis, who developed the picture of obvious heart failure with the right side of her circulation as the primary site of her heart disease. At this point I must turn to Dr. Dunbar to help me with the recognition of the abnormalities in her heart and lungs.

Radiologist's Discussion

DR. DUNBAR: Her heart was definitely enlarged with some localized prominence of the pulmonary artery and some localized enlargement of the right ventricle. I would say that the initial film showed some increased vascularity of her lung fields but I don't think it is passive congestion. Since her pulmonary artery is big, I think immediately of mitral stenosis. However, her barium swallow showed no evidence of left atrial enlargement at all, which leaves me without any evidence of mitral valvular disease. The only real objective finding that I have is right-sided cardiac enlargement *without* passive pulmonary congestion. I therefore must think of vascular obstructions in the lung parenchyma. The cause of this would be either chronic lung disease or chronic arterial disease. Since I can't make a diagnosis of sarcoid, pulmonary fibrosis, scleroderma, or emphysema, I am rather stuck with arterial disease in the lungs. I must say that I cannot rule out stenosis of the pulmonary valve. All in all, I would like to call this a right heart enlargement due to capillary or precapillary obstruction within the lung.

Pulmonary Vasculitis

DR. WEISSLER: Dr. Dunbar then extends our concept of her disease from one which appears to be affecting the right ventricle in addition to the portal hepatic circulation to one located somewhere in the pulmonary vascular tree. He tells us that the peripheral lung fields look oligemic either because of a very low cardiac output or because of something involving the small blood vessels of the lung. What do you think about the pericardium, John? I forgot to mention that.

DR. DUNBAR: It's not a small heart. Certainly a constrictive pericarditis will make clear lung fields. I don't see calcium and I have no reason to think that there is pericardial disease. I don't think there is pericardial fluid.

Primary Heart Disease?

DR. WEISSLER: Let's see if we can decipher further what may be the problem. Here is a 32 year old female with heart disease. It is unlikely that this disease is arteriosclerotic or hypertensive heart disease. Could this be rheumatic heart disease? Silent mitral stenosis is a very important diagnostic rule-out in a young female with pulmonary hypertension. By *silent* mitral stenosis we mean true mitral stenosis that is not reflected by the classic signs. Often this occurs in a thickly calcified mitral valve where there is extreme pulmonary hypertension and the patient looks as though he has primary problems in the pulmonary vascular tree. However, the prime indication for this condition is an enlarged left atrium, which was not present in this case. Could the patient have congenital heart disease? A silent interatrial septal defect may present a problem of congestive heart failure of unknown etiology, but in this disease cyanosis is usually noticeable at the time the patient comes to you and I think I'll have to rule out that one.

Primary Pulmonary Disease?

Could this woman have had a primary pulmonary process? I think Dr. Dunbar assures us, and so does her history, that she did not have primary parenchymal lung disease of the infectious type, but she could have had primary or secondary disease of the small blood vessels in her lungs. We are told of the pain in the thighs, and she actually had hemoptysis. Therefore the possibility that she had pulmonary hypertension secondary to multiple small pulmonary emboli is real. She also could have primary pulmonary hypertension, which is a disease of young females that develops generally over a period of two to four years.

Finally, could she have had primary myocardial disease? I am sure most of us thought of alcoholic myocardial myopathy. However, she had too much right-sided heart disease to blame it all on the myocardium. So I'll accept small blood vessel disease in the lung, and I hope that perhaps the pathologist can show us a primary site for her pulmonary emboli that complicated this woman's cirrhosis, together with a primary myocardiopathy due to alcoholism.

General Clinical Discussion

DR. ATWELL: Do I understand that your diagnosis is cirrhosis of the liver . . .?

DR. WEISSLER: Accentuated markedly by right-sided heart failure.

DR. ATWELL: You don't think she had cardiac cirrhosis?

DR. WEISSLER: Well, that's a hard one. I think that she had primary cirrhosis and that central venous congestion will be present as well.

DR. GREENBERGER: In so-called cardiac cirrhosis one may see portal to portal or portal to central scarring, but true full-blown cardiac cirrhosis is much rarer than people think. It usually develops against a background of long-standing congestive heart failure, of much longer duration than was present in this case.

DR. ATWELL: And your thought, Dr. Weissler, as to her final episode with all the fever, etc.?

DR. WEISSLER: I would have to say that she was necrosing lung tissue. I think that this woman did have a hidden infection somewhere and the one site that hasn't been completely ruled out is the kidney.

DR. MCCOY: This patient with her hypergammaglobulinemia and her rather nonspecific liver disease makes me think of lupoid hepatitis.

DR. WEISSLER: I did not want to extend myself too much.

DR. WOOLEY: On what basis are you excluding a diagnosis of subacute bacterial endocarditis since you are looking for a source whereby you can get emboli to the lungs? Couldn't she have had a right-sided endocarditis?

DR. WEISSLER: In spite of her negative blood cultures, right-sided SBE is a very distinct possibility.

DR. PERKINS: Was atrial myxoma one of the things that you decided not to comment on?

DR. WEISSLER: Well, no; actually, I don't think of atrial myxoma here. I am looking for an explanation of the protocol, and I think the best explanation is still a small blood vessel disease in the lung leading to right-sided heart failure. Perhaps the small blood vessel disease in the lung is reflecting some small blood vessel disease throughout the body, and she does have cirrhosis in addition.

DR. ATWELL: Dr. von Haam, are you going to tell us the answer?

DR. VON HAAM: This was really an unusually complicated case and I do not think the final answer can be irrevocably and undeniably made.

CLINICAL DIAGNOSIS

1. Nutritional cirrhosis of the liver.
2. Chronic alcoholic myocardiopathy.
3. Pulmonary hypertension due to small vessel disease.

PATHOLOGICAL DIAGNOSIS

1. Chronic idiopathic pulmonary hypertension.
2. Chronic myocardiopathy, type undetermined.
3. Cirrhosis of the liver (infectious?).

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The body was well developed and moderately well nourished and showed slight cyanosis of the lips and nail beds. The heart was moderately enlarged and weighed 440 Gm.; most of the enlargement was due to hypertrophy of the myocardium of the right ventricle, which was half as thick as that of the left ventricle. The pulmonary artery appeared moderately dilated and showed patchy atheromatous changes. Her lungs weighed 250 and 350 Gm. and appeared perfectly normal. Her spleen was firm and moderately enlarged. Her liver weighed 2150 Gm. and had a nodular surface. No varicosities were noted in the esophagus. Her kidneys were moderately enlarged but were smooth. There was gross evidence of endometriosis in both ovaries. Her brain was small and weighed only 1000 Gm.

The microscopic examination of the heart confirmed the marked hypertrophy of the right ventricle. However, many of the heart muscle fibers were separated by edematous fibrous tissue, indicating a degenerative process compatible with thiamine deficiency or myocardial ischemia. This degenerative process was not as marked in the left ventricle. Her lungs showed definite arteriosclerosis of the large and medium sized pulmonary vessels. The small vessels showed occlusion of the lumen with recanalization. The adventitia of many vessels showed inflammatory changes suggesting the presence of some type of vasculitis. There were also present small foci of hemosiderosis as found in Goodpasture's syndrome and evidence of small hemorrhages which had broken into small bronchi.

The microscopic sections of the spleen showed perivascular adventitial fibrosis in the form of "onion rings," which we usually see in lupus erythematosus. The liver showed a rather irregular pattern of cirrhosis with many perfectly normal liver lobules. There were some liver cells which were enlarged and pyknotic, compatible with hepatitis. A few vessels in the pancreas also showed evidence of a nonspecific periarteritis rich in plasma cells and lymphocytes. Sections of the kidneys showed only focal areas of pyelonephritis with evidence of heavy proteinuria. There were no changes suggestive of lupus or glomerulonephritis. The striated muscle showed degenerative phenomena compatible with Zenker's degeneration. Her brain also showed evidence of small vessel disease with small hyaline thrombi and focal gliosis. She also had the chronic granulomatous ependymitis sometimes seen in Wernicke's disease. The meninges were not involved.

To put the entire picture together and relate it to her hypergammaglobulinemia, I would suggest that the patient suffered from small vessel disease, or a forme fruste of lupus, which belongs in the group of

collagen diseases. Her small vessel lesions were located primarily in the lungs, producing a picture identical to that seen in primary idiopathic pulmonary hypertension. In addition, the degenerative changes in her myocardium fulfill some, but not all, criteria of alcoholic myocardiopathy. I believe that her liver cirrhosis was not nutritional in origin but can be explained either on an infectious or vascular basis. The vessel changes in the spleen and pancreas also are suggestive of some collagen disorder which for some unexplained reason had spared her kidneys.

General Discussion

DR. ATWELL: Dr. Weissler, do you have any comments?

DR. WEISSLER: I worry about the fact that Dr. von Haam showed us one onion-skin vessel in the spleen and didn't show us any diseased small blood vessels in the liver to corroborate his impression of lupus hepatitis.

DR. VON HAAM: With regard to the liver, I was really not impressed. I always was holding out for infectious hepatitis, but when I heard lupus mentioned in the discussion, suddenly a bell rang.

DR. WEISSLER: You find some solitary vessel disease in the periphery and you are trying to make this lung disease part of a general vessel disease. I think she had a primary blood vessel disease in the lung. Nowadays cardiologists are very loath to diagnose primary idiopathic pulmonary hypertension. This is why I called it small blood vessel disease of the lungs because I am still not sure that this disease isn't due to showers of tiny emboli in the small blood vessels which over a period of months or years resolved and recurred. So I don't think that finding a sparse vascular disease in any organ system designates this case a disease of the vessels generally. I think this may be a secondary phenomenon.

DR. VON HAAM: How do you explain her hypergammaglobulinemia and her liver disease?

DR. GREENBERGER: I think the liver as we saw it and the liver function tests indicate that this woman had severe chronic liver disease despite the involvement of some parts of her liver and the sparing of other parts. I think this is consistent with what they call lupoid hepatitis.

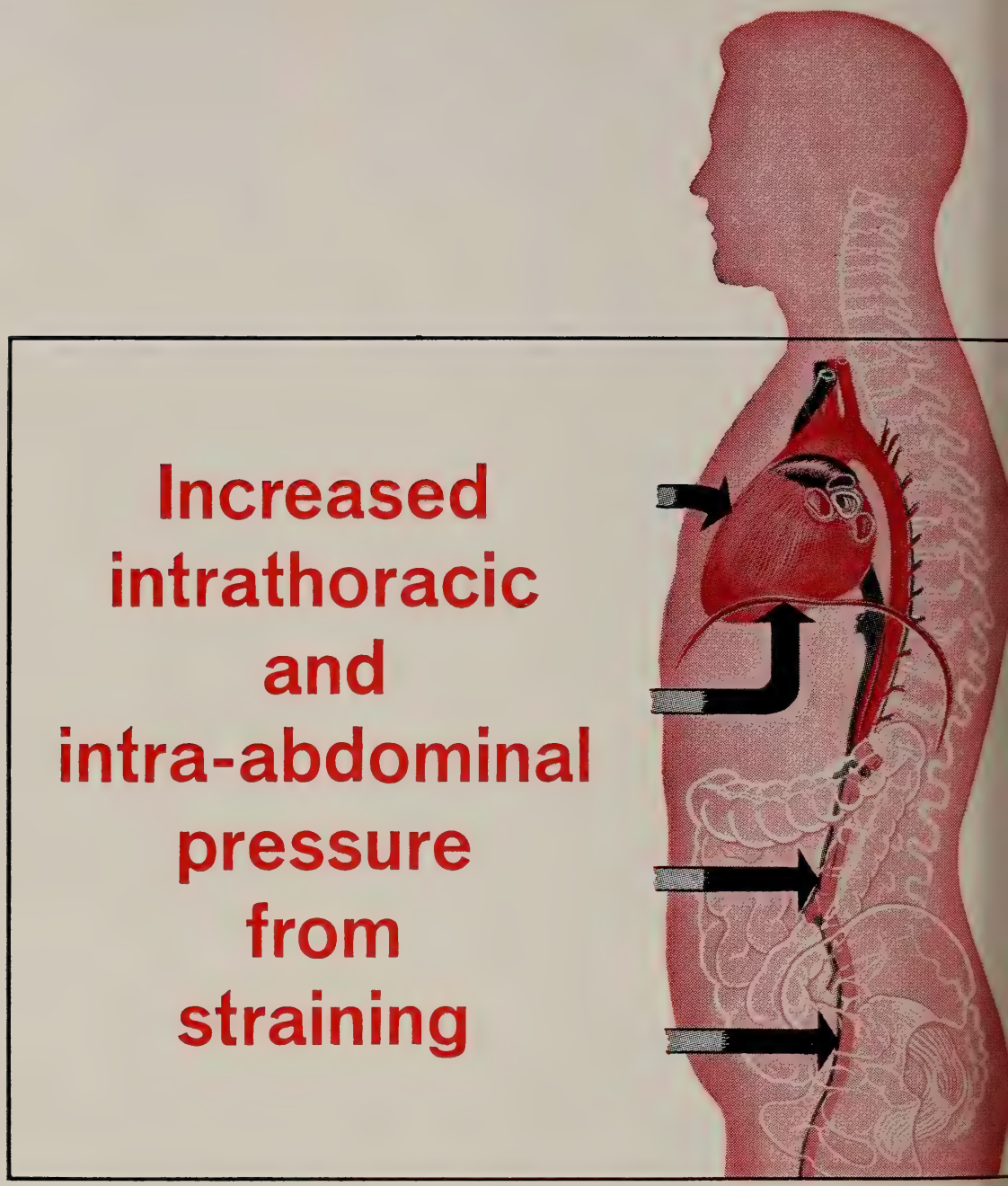
DR. PERKINS: I woud just like to mention that pulmonary vasculitis has been described in patients with chronic liver disease. This was reported in *Circulation* four or five years ago in a very succinct editorial. Some people thought it was due to disturbance in the protein metabolism, but I think this has been denied.

DR. VON HAAM: Yes, experimentally it has been denied.

DR. PERKINS: But I still think we should look for pulmonary vascular disease in patients with cirrhosis and other liver lesions.

DR. WEISSLER: If this woman had a small blood vessel disease in the lungs, this would be compatible with the diagnosis of primary pulmonary hypertension. This much chronic pulmonary hypertension with right ventricular failure, tremendous right ventricular hypertrophy, without small blood vessel disease in the heart, is not the kind of small blood vessel disease one gets in collagenosis. This is my point.

STEROIDS AND SHOCK. — Cardiac output and intravascular pressure were measured before and after large intravenous doses of hydrocortisone, methylprednisolone, prednisolone, or dexamethasone in nine normal subjects and nine patients in shock. The glucocorticoids caused a highly significant increase in cardiac output, usually beginning within one-half hour and continuing throughout the 90-minute study period. Control studies in nine unselected patients with various diagnoses showed that the changes in cardiac output produced by the steroids were not due to spontaneous variations or to the experimental conditions. After glucocorticoid administration, intraarterial pressure was not elevated despite the increased cardiac output, indicating that peripheral arterial resistance was decreased. Central venous pressure was usually unchanged by steroid administration. The increase in cardiac output and decrease in peripheral resistance induced by glucocorticoids are opposite to the hemodynamic fault that occurs in shock due to hypovolemia, myocardial injury, or gram-negative endotoxin, namely, reduced cardiac output and increased vasoconstriction. The present study did not define the distribution of the steroid-induced increase in systemic blood flow to the regional circuits. Whether the effects of glucocorticoids on systemic blood flow lead to improvement in perfusion of vital tissues and a reduction in oxygen debt is the subject of a future study. — ABSTRACT: M. P. Sambhi, Max H. Weil, M. D., and V. N. Udhoji, Los Angeles: *Circulation,* 31:523-530, (April) 1965.



Increased intrathoracic and intra-abdominal pressure from straining

METAMUCIL®

brand of psyllium hydrophilic mucilloid

Metamucil Powder: 4, 8 and 16-ounce containers. Instant Mix Metamucil: cartons of 16 and 30 single-dose packets.

Announcing

THE OFFICIAL PROGRAM

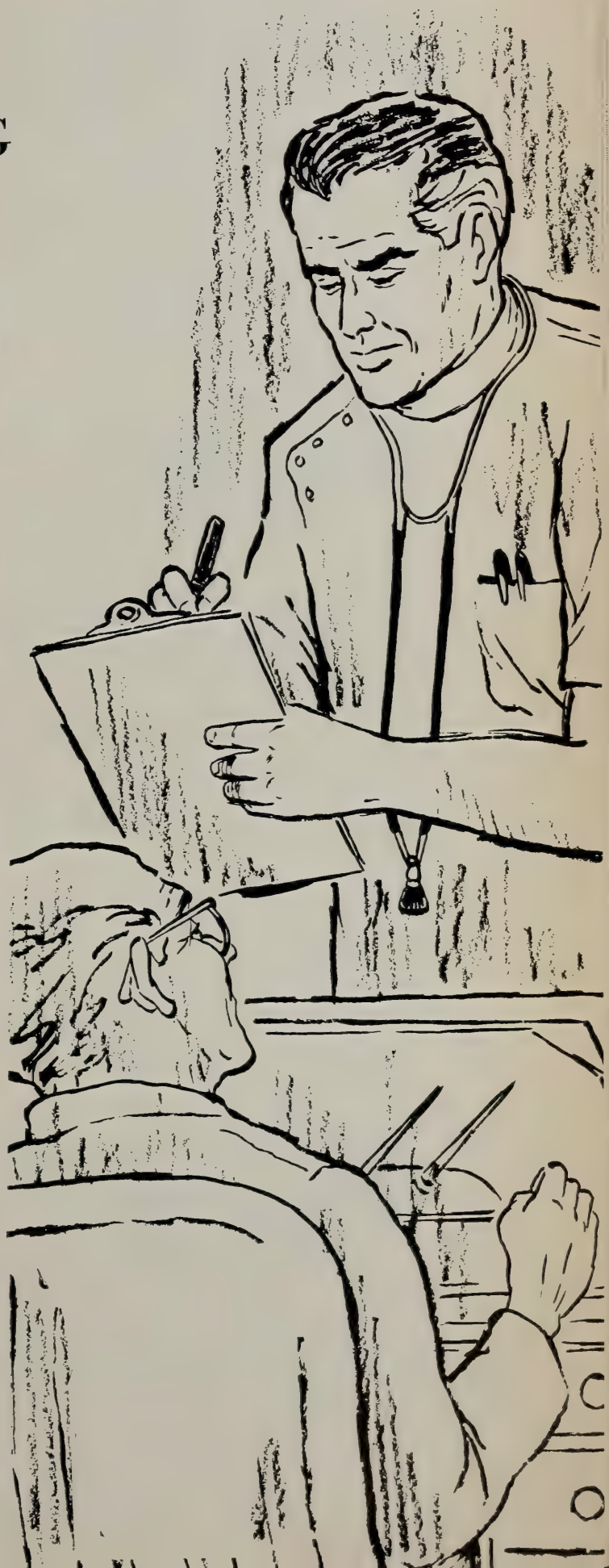
for the

1966 ANNUAL MEETING

of your

OHIO STATE MEDICAL ASSOCIATION

Cleveland **May 24-28**



The 118th Annual Meeting
is dedicated to
HERBERT M. PLATTER, M. D.
who retired January 1, 1966, after forty-eight years of Service to the Medical Profession as Secretary of the Ohio State Medical Board. The meeting itself has a . . . NEW LOOK . . . a new schedule, new features, an expanded scientific exhibit and others. Highlights of the meeting and a brief Daily Schedule follow on pages 350-353. Consult these daily schedules for time and place of event; then, for details as to subjects, speakers, etc., turn to the chronological program beginning on page 354.

Highlights . . .

(All Times are Daylight Saving Time)

Time and Place: Sessions of the **House of Delegates:** Tuesday, May 24, beginning with a dinner at 6:00 P. M. and Friday, May 27, at 9:00 A. M.; both sessions at the Sheraton-Cleveland Hotel, Cleveland. **Resolutions Committees:** These will meet on Wednesday, May 25, beginning at 9:00 A. M. at the Sheraton-Cleveland Hotel and will continue to meet until their business is completed. **Exhibits** will open at 10:00 A. M., Wednesday, May 25, at the Sheraton-Cleveland Hotel and the first scientific session will begin at 1:30 P. M., Wednesday, May 25, in the Cleveland Room, also at the Sheraton-Cleveland Hotel.

Registration: Headquarters for Registration is the Grand Ballroom Foyer, Mezzanine Floor, Sheraton-Cleveland Hotel. It will open at 10:00 A. M. on Wednesday, May 25, and will remain open until 5:30 P. M. Registration on Thursday, May 26, and Friday, May 27, will be open from 9:00 A. M. to 5:30 P. M. and on Saturday, May 28, from 9:00 A. M. until 12:00 noon. Special provisions will be made to register persons attending sessions of the House of Delegates and its Resolutions Committee meetings.

Those eligible to register are members of the Ohio State Medical Association (who should present 1966 Membership Cards at time of registration); physicians from other states who are members of their respective state medical associations; residents, interns and medical students; nurses, health workers and others who are presented as guests at Registration Headquarters by members. Letters of introduction on members' stationery also will be honored at Registration Headquarters. The Woman's Auxiliary will provide registration for its members and others who are eligible to attend Auxiliary sessions in the Sheraton-Cleveland Hotel, Main Lobby West.

Scientific, Health Education and Technical Exhibits: The Scientific Exhibit will be on the Grand Ballroom Balcony; the Health Education Exhibit in the Exhibit Hall and the Technical Exhibit in the Grand Ballroom and Grand Ballroom Foyer. All exhibits will be open from 10:00 A. M. to 5:30 P. M. on Wednesday, May 25; from 9:00 to 5:30 on Thursday, May 26, and from 9:00 to 3:00 on Friday, May 27. Ample recesses have been scheduled in the program to allow frequent visits to the exhibits. All participants are urged to visit these exhibits.



ALL SCIENTIFIC and BUSINESS SESSIONS and ALL EXHIBITS UNDER ONE ROOF AT . . . SHERATON - CLEVELAND HOTEL

Emergency Telephone Service: The Yellow Pages Division of the Ohio Bell Telephone Company will maintain an information booth and paging service during the meeting. This booth will be located immediately adjacent to OSMA Registration Headquarters in the Grand Ballroom Foyer and will be open daily while meetings are in session. Names of physicians called will be placed on a bulletin board at the booth and in the General Session meeting room. Two telephone numbers will be used:

For Cleveland Physicians	231-3500
For all others	861-8000

Scientific Program: Sessions begin on Wednesday, May 25, at 1:30 P. M. with a General Session Program on "Problems in Marriage." Scientific sessions will continue through Saturday, May 28, at 12 noon. All will be held at the Sheraton-Cleveland Hotel. Consult the detailed program for a complete listing and specific information regarding program content, speakers, etc.

President's Reception: This principal social event of the Annual Meeting is scheduled on Friday, May 27, beginning at 6:00 o'clock in the Gold and Whitehall Rooms, Sheraton-Cleveland Hotel. There will be no dinner; merely an informal gathering with refreshments. Dress is optional for members and their guests. Dancing with music by the Bob Lorence Orchestra and Salli Lynn, vocalist, will be provided.

The Woman's Auxiliary: The Woman's Auxiliary to the Association will meet the same week as the OSMA meeting with headquarters also at the Sheraton-Cleveland Hotel. All ladies eligible for membership in the Auxiliary are invited to attend sessions and special events. The Auxiliary is providing registration facilities at the Sheraton-Cleveland Hotel, Main Lobby West.

Specialty Societies: A number of Specialty Societies are cooperating with the Association in various phases of the program, and several are holding meetings or special events during the week. These include the following:

Ohio Psychiatric Association

Ohio Ophthalmological Society

Ohio Committee on Trauma,
American College of Surgeons

Ohio Society of Internal Medicine

Ohio State Surgical Association

Ohio Chapter, American Academy of Pediatrics

Ohio Ear, Nose and Throat Society

Ohio Society of Physical Medicine
and Rehabilitation

Ohio Orthopaedic Society

Ohio Chapter,
American College of Chest Physicians

Ohio Society of Pathologists

Ohio Neurosurgical Society

Consult the detailed program for specific information regarding these specialty society activities.

THURSDAY, MAY 26

General Session

(Gold Room, Mezzanine Floor)

1:30 P. M.

"Medicare's Rules and Regulations and Their Effect on the Practice of Medicine"

CHARLES L. HUDSON, M. D.
Cleveland, Ohio
President-Elect, American Medical Association



FRIDAY, MAY 27

General Session

(Gold Room, Mezzanine Floor)

1:30 P. M.

"Care of the Patient: 1966"

EDWARD R. ANNIS, M. D.
Miami, Florida
Past President, American Medical Association



ONE OF THE NATION'S FINEST AND LARGEST POSTGRADUATE MEDICAL ASSEMBLIES



SUMMARY OF

DAILY SCHEDULE

ALL TIMES DAYLIGHT SAVING TIME

ALL EVENTS AT SHERATON-CLEVELAND HOTEL UNLESS OTHERWISE INDICATED

TUESDAY, MAY 24

(See page 354 for detailed schedule)

5:00 P. M.

OSMA House of Delegates Registration

(Gold Room Assembly, Mezzanine Floor)

6:00 P. M.

OSMA House of Delegates Complimentary Dinner

(Whitehall Room, Mezzanine Floor)

7:30 P. M.

OSMA House of Delegates First Business Session

(Gold Room, Mezzanine Floor)

Herbert Morris Platter, M. D., Secretary of the Ohio State Medical Board for 48 years prior to his retirement on January 1, 1966, and to whom the entire 1966 Annual Meeting is dedicated, will be honored. See detailed program for specific information about ceremonies.

WEDNESDAY, MAY 25

(See pages 356 to 358 for detailed schedule)

9:00 A. M.

Resolutions Committee No. 1

(Whitehall Room, Mezzanine Floor)

Resolutions Committee No. 2

(Empire Room, Parlor Floor)

Resolutions Committee No. 3

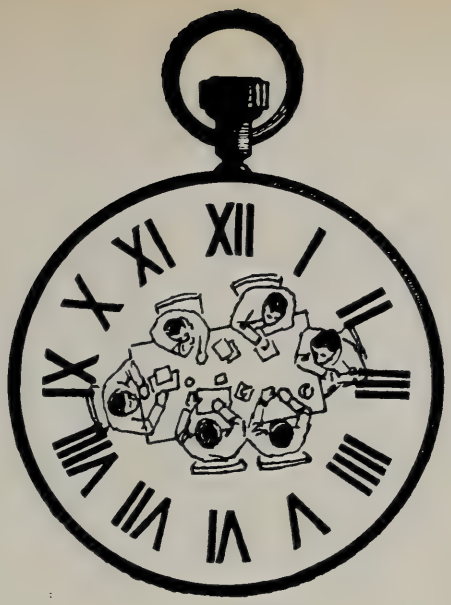
(Terminal Room, Parlor Floor)

Committee on President's Address

(Teepee Room, First Floor)

Registration for Exhibitors Opens

(Grand Ballroom Foyer, Mezzanine Floor)



WEDNESDAY (Contd.)

10:00 A. M.

OSMA Registration Opens
(Grand Ballroom Foyer, Mezzanine Floor)

Scientific, Health-Education and Technical Exhibits Open
(Grand Ballroom and Ballroom Balcony)

11:30 A. M.

Ohio Medical Political Action Committee and AMPAC Luncheon
(Gold Room, Mezzanine Floor)

1:00 P. M.

Ohio Health Commissioners' Meeting with Director
(Grand Ballroom — Terrace, Parlor Floor)

1:30 P. M.

General Session
"Problems in Marriage"
(Cleveland Room, Lobby Floor)

2:00 P. M.

Ohio Health Commissioners' Institute
FIRST SESSION
(Grand Ballroom — Terrace, Parlor Floor)

2:30 P. M.

Ophthalmology
(Lewis Room, Lobby Floor)

3:00 P. M.

Intermission for Tour of Exhibits

3:30 P. M.

General Session
"What I Do About It"
(Gold Room, Mezzanine Floor)

WEDNESDAY (Contd.)

4:00 P. M.

Organizational Meeting of Hospital Directors of Medical Education
(Mohawk Room, First Floor)

THURSDAY, MAY 26
(See pages 359 to 362 for detailed schedule)

8:30 A. M.

Film:
"A New Look at Tetanus Prophylaxis"
(Gold Room, Mezzanine Floor)

9:00 A. M.

General Session
"Athletic Injuries"
(Gold Room, Mezzanine Floor)

9:00 A. M.

OSMA Registration Opens
(Grand Ballroom Foyer, Mezzanine Floor)

Scientific, Health-Education and Technical Exhibits Open
(Grand Ballroom and Ballroom Balcony)

9:00 A. M.

Ohio Health Commissioners' Institute
SECOND SESSION
(Lewis Room, Lobby Floor)

9:00 A. M.

Psychiatry
(Grand Ballroom — Terrace, Parlor Floor)

9:30 A. M.

Executive Session of Resolutions
COMMITTEE NO. 1
(Wigwam Room, First Floor)



THURSDAY (Contd.)

Executive Session of Resolutions
COMMITTEE No. 2
(Mohawk Room, First Floor)

Executive Session of Resolutions
COMMITTEE NO. 3
(Chieftain Room, First Floor)

10:30 A. M.

Intermission for Tour of Exhibits

11:00 A. M.

Continuation of General Session and Scientific Section Meetings

1:30 P. M.

GENERAL SESSION

"Medicare's Rules and Regulations and Their Effect on the Practice of Medicine" —
Charles L. Hudson, M. D., President-Elect
American Medical Association
(Gold Room, Mezzanine Floor)

2:30 P. M.

Intermission for Tour of Exhibits

3:00 P. M.

Anesthesiology
(Terminal Room, Parlor Floor)

Internal Medicine
(Gold Room, Mezzanine Floor)

Psychiatry
(Grand Ballroom — Terrace, Parlor Floor)

Ohio State Surgical Association
(Whitehall Room, Mezzanine Floor)

THURSDAY (Contd.)

Ohio Health Commissioners' Institute
THIRD SESSION
(Lewis Room, Lobby Floor)

Ohio Academy of Medical History
(Erie Room, Parlor Floor)

FRIDAY, MAY 27
(See pages 363 to 369 for detailed schedule)

7:30 A. M.

Woman's Auxiliary Breakfast
(Cleveland Room, Lobby Floor)

8:30 A. M.

Ohio Health Commissioners' Institute
FOURTH SESSION
(Lewis Room, Lobby Floor)

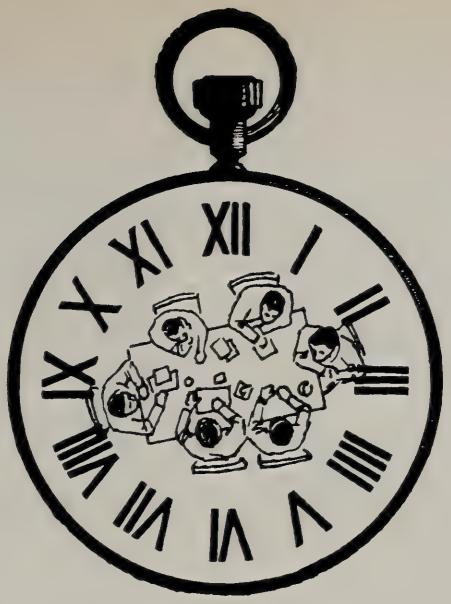
9:00 A. M.

OSMA Registration Opens
(Grand Ballroom Foyer, Mezzanine Floor)

Scientific, Health-Education and Technical Exhibits Open
(Grand Ballroom and Ballroom Balcony)

Medical Booth Seminars
(Exhibit Hall Area)

Starting time: 9:00, 10:00 and 11:00 A. M.
Booth No. 1 — "Conditioning, Prevention and First Aid for Athletic Injuries"
Booth No. 3 — "Bedside Pulmonary Function Testing"
Booth No. 5 — "Physical Medicine in the Home"
Starting time: 9:30, 10:30 and 11:30 A. M.
Booth No. 2 — "Resuscitation"
Booth No. 4 — "Lacerations"
Booth No. 6 — "Fractures"



FRIDAY *(Contd.)*

9:00 A. M.

OSMA House of Delegates
FINAL SESSION
(Gold Room, Mezzanine Floor)

11:00 A. M.

Ohio State Surgical Association
Business Meeting and Installation of Officers
(Terminal Room, Parlor Floor)

1:30 P. M.

General Session
"Care of the Patient: 1966" — Edward R. Annis, M. D., Past President, American Medical Association
(Gold Room, Mezzanine Floor)

2:30 P. M.

Orthopaedic Surgery
(Lewis Room, Lobby Floor)

2:30 P. M.

Intermission for Tour of Exhibits

3:00 P. M.

General Practice; Obstetrics and Gynecology and Pediatrics
(Gold Room, Mezzanine Floor)

EAR, NOSE AND THROAT
(Terminal Room, Parlor Floor)

Occupational Medicine
(Erie Room, Parlor Floor)

Physical Medicine and Rehabilitation
(Navajo Room, First Floor)

Radiology and Chest Physicians
(Whitehall Room, Mezzanine Floor)

FRIDAY *(Contd.)*

Pathology
(Cleveland Room, Lobby Floor)

Neurosurgery
(Empire Room, Parlor Floor)

3:00 P. M.

All Exhibits Close

6:00 P. M.

OSMA President's Reception
(Whitehall and Gold Rooms, Mezzanine Floor)

SATURDAY, MAY 28
(See page 370 for detailed program)

9:00 A. M.

OSMA Registration Opens
(Grand Ballroom Foyer, Mezzanine Floor)

9:00 A. M.

Conference on Laboratory Medicine
(Gold Room, Mezzanine Floor)

12:00 NOON

Organizational Meeting Luncheon, Ohio Association of Blood Banks
(Gold Room, Mezzanine Floor)

9:00 A. M. - 12:00 NOON

Clinical Conference Ohio Chapter, American Academy of Pediatrics
(Babies and Childrens Hospital)

12:00 Noon

OSMA Annual Meeting Closes

12:00 to 12:30 P. M.

Ohio Chapter, American Academy of Pediatrics Annual Meeting
(Babies and Childrens Hospital)

TUESDAY, MAY 24

5:00 P. M. (D. S. T.)

House of Delegates Registration

(Gold Room Assembly, Mezzanine Floor)

6:00 P. .M (D. S. T.)

House of Delegates Complimentary Dinner for Delegates, Alternates, and OSMA Council

(Whitehall Room, Mezzanine Floor)

7:30 P. M. (D. S. T.)

House of Delegates First Business Session

(Gold Room, Mezzanine Floor)

Invocation — The Reverend Frederick T. Schumacher, The First Church in Oberlin, Oberlin.

Welcome by David Fishman, M. D., Cleveland, Academy of Medicine of Cleveland and Cuyahoga County.

Introduction of President Henry A. Crawford, M. D., Cleveland.

Roll Call of Delegates.

Consideration of the Minutes of the last Annual Meeting (July, 1965 issue of *The Journal).*

Introduction of honored guests.

Presentation of AMA-ERF checks to representatives of the University of Cincinnati College of Medicine; Western Reserve University School of Medicine; and Ohio State University College of Medicine — Robert S. Martin, M. D., Chairman, Ohio Committee on AMA-ERF.

Presentation of plaques honoring physicians serving with Project Viet Nam — Dr. Crawford.

Ceremonies honoring Herbert Morris Platter, M. D., Secretary of the Ohio State Medical Board for 48 years, to whom the entire 1966 Annual Meeting is dedicated. Participating in the ceremonies will be: Dr. Henry A. Crawford, President of the Ohio State Medical Association, Lt. Governor John W. Brown and others.

Report by the President of the Woman's Auxiliary — Mrs. Herbert F. VanEpps, Dover.

Appointment of Reference Committees by the President:

Credentials
President's Address
Resolutions
Tellers and Judges of Election

Nomination and election of Committee on Nominations: (Nominations from the floor. One representative (delegate) from each Councilor District. The Committee shall report to the Final Session, Friday, May 27, 9:00 A. M., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Friday morning session before any action can be taken. All resolutions must be typewritten and submitted in triplicate.)

Announcement of meeting places of Reference Committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	Francis L. Stevens	Juan Young
BROWN	John R. Donohoo	
BUTLER	John H. Varney	James L. Sawyer
	Paul N. Ivins	James A. Stewart
CLERMONT	Carl A. Minning	Richard K. Lancaster
CLINTON	Edmond K. Yantes	H. Richard Bath
HAMILTON	Ralph S. Grace	Bruce G. MacMillan
	Garfield L. Suder	Taylor W. Barker
	Howard F. C. Pfister	Louis C. Buente
	Joseph E. Ghory	Eli Rubenstein
	John J. Cranley, Jr.	Kenneth A. J. Frederick
	Joseph G. Crotty	William C. Ahlering
	Clyde S. Roof	Frederick Brockmeier
	Daniel V. Jones	Robert S. Heidt
	Robert M. Woolford	Warner A. Peck
	Harry K. Hines	Joseph J. Podesta
	Carl W. Koehler	Glenn W. Pfister, Jr.
	Charles A. Sebastian	
	Frank P. Cleveland	
HIGHLAND	J. Martin Byers	Clifford G. Foor
WARREN	Thomas E. Fox	Orville L. Layman

Counties	Delegates	Alternates
SECOND DISTRICT		
CHAMPAIGN	Isador Miller	Victor R. Frederick
CLARK	Ernest H. Winterhoff	Charles J. Townsend
	David D. Smith	Max H. Gerke
DARKE	Maurice M. Kane	V. Ray Boli
GREENE	Roger C. Henderson	Paul C. Vernier
MIAMI	Dale A. Hudson	Jerry L. Hammon
MONTGOMERY	Sylvan L. Weinberg	M. V. Lingle
	J. Richard Strawsburg	Daniel E. Brannen
	James G. Tye	John Robert Brown
	Robert A. Bruce	John H. Muehlstein
	William M. Porter	John R. Keys
	Kenneth D. Arn	
PREBLE	Chester J. Brian	Willard C. Clark, Jr.
SHELBY	George J. Schroer	Thomas W. Hunter

DELEGATES AND ALTERNATES (Contd.)

Counties	Delegates	Alternates
THIRD DISTRICT		
ALLEN	Dwight L. Becker Fred P. Berlin	Ronald P. Bell John A. Glorioso
AUGLAIZE	Robert S. Oyer	Elizabeth Y. Kuffner
CRAWFORD	Darrel D. Bibler	Horace B. Newhard
HANCOCK	Donald R. Brumley	
HARDIN	Clarence L. Johnson	William F. Binkley
LOGAN	Ralph K. Updegraff	Charles A. Browning, Jr.
MARION	Albert M. Mogg	Paul E. Lyon
MERCER	Donald R. Fox	George H. McIlroy
SENECA	Walter A. Daniel	Emmet T. Sheeran
VAN WERT	Edwin William Burnes	Edward E. White
WYANDOT	Donald Phillip Smith	Richard L. Garster
FOURTH DISTRICT		
DEFIANCE	Charles E. Jaeckle	Francis M. Lenhart
FULTON	William J. Neal	Vernon L. Cotterman
HENRY	Edwin C. Winzeler	Homer C. Brown
LUCAS	Edmond F. Glow William G. Henry Edward F. Ockuly Frederick P. Osgood F. F. A. Rawling Max T. Schnitker	George N. Bates Edward L. Doermann J. B. Sawyer Merl B. Smith Gordon M. Todd R. P. Whitehead
OTTAWA	V. William Wagner	Cyrus R. Wood
PAULDING	Doyt E. Farling	Edythe C. Pritchard
PUTNAM	Milo B. Rice	James B. Overmier
SANDUSKY	John G. Bushman	Carroll D. Miller
WILLIAMS	Allen G. Jackson	Robert W. Dilworth
WOOD	Paul F. Orr	Clarence B. Nyce
FIFTH DISTRICT		
ASHTABULA	Shepard A. Burroughs	James G. Macaulay
CUYAHOGA	Joseph C. Avellone James O. Barr Joseph L. Bilton William F. Boukalik John H. Budd E. Peter Coppedge Eduard Eichner David Fishman William E. Forsythe John J. Grady Harry A. Haller Chester R. Jablonoski Fred R. Kelly Vincent T. LaMaida Middleton H. Lambright L. Philip Longley Lawrence J. McCormack Paul A. Mielcarek George W. Petznick John H. Sanders A. B. Schneider, Jr. Frederick T. Suppes Elden C. Weckesser	Christopher A. Colombi Russell B. Crawford Nicholas G. DePiero John J. Gaughan Ray W. Gifford, Jr. Harry R. Grau Edward O. Hahn Charles H. Jobe Herbert H. Johnson, Jr. Roscoe J. Kennedy Richard P. Levy Frederick V. Light Joseph P. Martin Thomas E. Meaney Hermann Menges, Jr. Russell P. Rizzo Frederick R. Schnell Lawrence P. Schumake Edward E. Siegler Leo H. Simoson William V. Trowbridge Robert F. Williams
GEAUGA	Simon Ohanessian	Bruce F. Andreas
LAKE	Robert A. Irvin Joseph W. Koelliker, Jr.	Herbert S. Wells Maxwell Burnham
SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	Leonard S. Pritchard
MAHONING	Joseph V. Newsome Charles W. Stertzbach Leonard P. Caccamo Jack Schreiber	Hugh N. Bennett Joseph W. Tandatnick Robert B. McConnell Frederick A. Friedrich
PORTAGE	Edward A. Webb	David Palmstrom
STARK	William A. White, Jr. Aubrey R. Furnas, Jr. Maurice F. Lieber Mark G. Herbst	Andreas S. Ahbel Frank O. Goodnough Edward E. Grable Richard V. Skibbens
SUMMIT	James W. Parks Francis J. Waickman William Dorner, Jr. Leonard V. Phillips Thomas W. Jackson Robert E. Yeakley	James G. Roberts Robert R. Clark Melvin E. Farris Uffe Trier Jensen W. Paul Kilway, Jr. Russell L. Platt
TRUMBULL	Rex K. Whiteman L. A. Loria	Raymond Ralston Steven A. Pollis

Counties	Delegates	Alternates
SEVENTH DISTRICT		
BELMONT	James F. Sutherland	David M. Creamer
CARROLL	Samuel L. Weir	Carl A. Lincke
COSHOCTON	Norman L. Wright	N. Harry Carpenter
HARRISON	Charles D. Evans, Jr.	Gerald E. Vorhies
JEFFERSON	Sanford Press	Crist G. Strovilas
MONROE	Byron Gillespie	
TUSCARAWAS	Robert E. Rinderknecht	William E. Hudson
EIGHTH DISTRICT		
ATHENS	Don R. Johnson	Herbert N. Whanger
FAIRFIELD	Jack L. Kraker	William S. Jasper
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	Jay Ross Wells	R. Gilbert Mannino
MORGAN	Austin A. Coulson	Henry Bachman
MUSKINGUM	Joseph C. Greene	Carl E. Spragg
NOBLE	Edward G. Ditch	Frederick M. Cox
PERRY	Charles E. Bope	Michael P. Clouse
WASHINGTON	Kenneth E. Bennett	George E. Huston
NINTH DISTRICT		
GALLIA	Thomas W. Morgan	James A. Kemp
HOCKING	Richard C. Jones	L. W. Starr
JACKSON	Clarence C. Fitzpatrick	John C. MacLennan
LAWRENCE	Thomas E. Miller	Harry Nenni
MEIGS	Roger P. Daniels	
PIKE	Mack E. Moore	Albert M. Shrader
SCIOTO	William M. Singleton	Sol Asch
VINTON	Richard E. Bullock	
TENTH DISTRICT		
DELAWARE	Adelbert R. Callander	Mary K. Kuhn
FAYETTE	Robert A. Heiny	Thomas J. Hancock
FRANKLIN	Homer A. Anderson William E. Hunt Allen D. Puppel Donald W. Traphagen Robert M. Inglis John R. Huston Joseph A. Bonta Charles W. Pavey Dale R. Dickens	Thomas M. Hughes Samuel Saslaw Mark Louis Saylor Charles J. Hatfield George O. Kress James C. Good Alexander Pollack Robert A. Heilman Norman H. Baker
KNOX	James C. McLarnan	Henry T. Lapp
MADISON	Sol Maggied	John C. Starr
MORROW	Joseph P. Ingmire	David James Hickson
PICKAWAY	Jasper M. Hedges	Carlos Alvarez
ROSS	Robert E. Swank	Lewis W. Coppel
UNION	E. J. Marsh	Fred C. Callaway
ELEVENTH DISTRICT		
ASHLAND	Charles H. McMullen	Myrle D. Shilling
ERIE	Emil J. Meckstroth	Richard H. Williamson
HOLMES	Adam J. Earney	Owen F. Patterson
HURON	William R. Graham	Earl R. McLoney
LORAIN	Ben V. Myers James T. Stephens	William H. Miller Max L. Durfee
MEDINA	Richard W. Avery	William G. Halley
RICHLAND	Carroll E. Damron Stanley L. Brody	C. Karl Kuehne Carl M. Quick
WAYNE	Albert Burney Huff	Robert E. Reiheld

OFFICERS

Pres.	Henry A. Crawford	Treas.	Philip B. Hardymon
Pres.-Elect	L. C. Meredith	Past Pres.	Robert E. Tschantz

COUNCILORS

District		District	
First	Robert E. Howard	Seventh	Benj. C. Diefenbach
Second	Theodore L. Light	Eighth	Robert C. Beardsley
Third	Frederick T. Merchant	Ninth	George N. Spears
Fourth	Robert N. Smith	Tenth	Richard L. Fulton
Fifth	P. John Robechek	Eleventh	William R. Schultz
Sixth	Edwin R. Westbrook		

WEDNESDAY, MAY 25

9:00 A. M. (D. S. T.)

House of Delegates Resolutions Committees

RESOLUTIONS COMMITTEE NO. 1
(Whitehall Room, Mezzanine Floor)

RESOLUTIONS COMMITTEE NO. 2
(Empire Room, Parlor Floor)

RESOLUTIONS COMMITTEE NO. 3
(Terminal Room, Parlor Floor)

COMMITTEE ON PRESIDENT'S ADDRESS
(Teepee Room, First Floor)

COMMITTEE ON NOMINATIONS
(Chieftain Room, First Floor)

Any member of the Association is privileged to attend these meetings.

WEDNESDAY, MAY 25

9:00 A. M. (D. S. T.)

Registration for Exhibitors Open

(Grand Ballroom Foyer, Mezzanine Floor)

WEDNESDAY, MAY 25

10:00 A. M. (D. S. T.)

OSMA Registration Opens

(Grand Ballroom Foyer, Mezzanine Floor)

10:00 A. M. (D. S. T.)

Opening of Scientific, Health Education and Technical Exhibits

(Grand Ballroom and Ballroom Balcony)

WEDNESDAY, MAY 25

11:30 - 1:30 P. M. (D. S. T.)

Ohio Medical Political Action Committee — American Medical Political Action Committee Luncheon

11:30 - 12:00 Social Half-hour *(Cash Bar Open)*
(Gold Room Foyer, Mezzanine Floor)

12:00 - 12:45 Luncheon
(Gold Room, Mezzanine Floor)

12:45 - 12:55 Presiding Officer: Frank H. Mayfield, M. D., Chairman, OMPAC

12:55 - 1:20 Speaker: Hoyt D. Gardner, M. D., Louisville, Kentucky, Member of AMPAC Board of Directors

"Success Can Be Ours"

Tickets for this luncheon are on sale for $5.00 per person. They may be purchased from your county Woman's Auxiliary legislative chairmen or by sending check in the amount of $5.00 to the Ohio Medical Political Action Committee, P. O. Box 5617, Columbus, Ohio 43221.

WEDNESDAY, MAY 25

1:30 P. M. (D. S. T.)

General Session

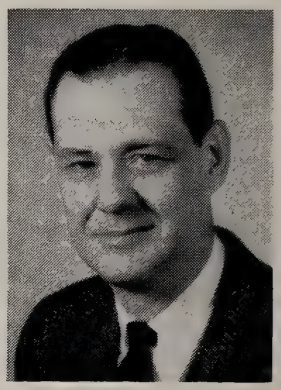
(Cleveland Room, Lobby Floor)

"Problems in Marriage"

Program sponsored by the Section on Psychiatry and Neurology and Ohio Psychiatric Association; cosponsored by all other OSMA Scientific Sections and OSMA Committee on Medicine and Religion.



Dean Loegler



Dr. Lovshin

THE PARTICIPANTS

Frances K. Harding, M. D., Columbus, Assistant Professor, Ohio State University.

The Very Reverend David Loegler, Cleveland, Dean of Trinity Cathedral.

Leonard L. Lovshin, M. D., Cleveland, Head of Department of Internal Medicine, Cleveland Clinic.

Miss Myra F. Thomas, Cleveland, District Director, Family Service Association.

Presiding: Dr. Lovshin.

1:30 Introductory Remarks — Dr. Lovshin.

1:40 **The Clergyman's Approach to Marriage Problems** — Dean Loegler

1:50 **Family Planning** — Dr. Harding

2:00 **How a Family Caseworker Approaches the Problems in Marriage** — Miss Thomas

2:10 **How a Psychiatrist Approaches the Problems in Marriage**

2:30 Panel Discussion.
Moderator: Dr. Lovshin.
Members of Panel:
Dr. Harding, Dean Loegler and Miss Thomas

3:00 Adjournment.

6:30 P. M. (D. S. T.)
(Lewis Room, Lobby Floor)

Dinner sponsored by the Ohio Psychiatric Association and the Cleveland Society of Neurology and Psychiatry.

HELP EXTEND THE PROFESSION'S

STRONG RIGHT ARM

Attend . . .

THE OHIO MEDICAL POLITICAL ACTION COMMITTEE LUNCHEON

Wednesday, May 25
Gold Room
Sheraton-Cleveland Hotel



Dr. Gardner

HOYT D. GARDNER, M.D.

Louisville, Kentucky
Member, Board of Directors
American Medical Political Action Committee

will speak on . . .

"Success Can Be Ours"

11:30 A. M. Cash Bar

12:00 Noon Luncheon

12:45 P. M. Progress Report on OMPAC
Frank H. Mayfield, M. D.
Chairman, OMPAC Board

12:55 P. M. "Success Can Be Ours"
Dr. Gardner

1:20 P. M. Question and Answer Period

Dr. Gardner's presentation will be aimed at giving guides to successful grass-roots political activity.

PLEASE COMPLETE THIS FORM AND FORWARD WITH CHECK TO

The Ohio Medical Political Action Committee
P. O. Box 5617
Columbus, Ohio 43221

Enclosed please find check in the amount of $_____, in payment for _____ tickets for the O.M.P.A.C. luncheon, Wednesday, May 25, 1966, at the Sheraton-Cleveland Hotel.

Please send tickets to: Name_____

Address_____

WEDNESDAY, MAY 25

2:30 P. M. (D. S. T.)

Ophthalmology

(Lewis Room, Lobby Floor)

Program sponsored by the Section on Ophthalmology, Ohio Ophthalmological Society and the Cleveland Ophthalmological Club.

THE PARTICIPANTS

James M. Andrew, M. D., Columbus, Associate Professor of Ophthalmology, Ohio State University College of Medicine.

Taylor Asbury, M. D., Cincinnati, Coordinator of Teaching Program for students and residents, Department of Ophthalmology, University of Cincinnati.



Dr. Bellows

John G. Bellows, M. D., Chicago, Illinois, Associate Professor of Ophthalmology, Northwestern Reserve University Medical School.

Frederick M. Kapetansky, M. D., Columbus, Assistant Professor of Ophthalmology, Ohio State University College of Medicine, Director of Glaucoma Clinic.

Torrence A. Makley, Jr., M. D., Columbus, Professor and Chairman of the Department of Ophthalmology, Ohio State University.

Daniel T. Weidenthal, M. D., Cleveland Attending Staff, St. Luke's and Mt. Sinai Hospitals.

2:30 **Current Status of Presumed Ocular Histoplasmosis** — Dr. Asbury

3:00 Discussion.

3:05 **Cryosurgery of Ocular Diseases** — Dr. Bellows

3:45 Discussion.

3:55 **Glaucoma under 40** — Dr. Andrew

4:05 **Glaucoma under 40** — Dr. Kapetansky

4:15 **Traumatic Retinal Detachment** — Dr. Weidenthal

4:45 Discussion.

4:50 **Uveitis in Children** — Dr. Makley

5:00 Election of Officers for 1967.

The foregoing program was arranged under the direction of the following: James M. Andrew, M. D., Columbus, Chairman, Russell J. Nicholl, M. D., Cleveland, Secretary, Section on Ophthalmology; Herbert Kesinger, M. D., Sandusky, President, Robert H. Magnuson, M. D., Columbus, Secretary, Ohio Ophthalmological Society.

6:30 P. M. (D. S. T.)

Cleveland Ophthalmological Club

(Wade Park Manor)

Cocktails and dinner. Guest speaker: John G. Bellows, M. D., Chicago; "Life History of the Lens." Tickets at $10 each may be secured at the door.

WEDNESDAY, MAY 25

3:30 P. M. (D. S. T.)

General Session

(Gold Room, Mezzanine Floor)

"What I Do About It"

Program presented by the Faculty, Western Reserve University School of Medicine, Cleveland.

Presiding: Samuel Saslaw, M. D., Columbus, Chairman, Committee on Scientific Work.

Jerome S. Abrams, M. D., Instructor, Department of Surgery.

John H. Davis, M. D., Instructor, Department of Surgery.

Brown M. Dobyns, M. D., Instructor, Department of Surgery.

Robert W. Hopkins, M. D., Senior Instructor, Department of Surgery.

Lester Persky, M. D., Associate Professor, Department of Urology.

Walter H. Pritchard, M. D., Professor, Department of Internal Medicine.

Maurice Victor, M. D., Instructor, Department of Neurology.

Austin S. Weisberger, M. D., Head of Department of Internal Medicine.

3:30 **What Splenectomy Has To Offer in Blood Dyscrasias and Other Disorders** — Dr. Davis.

3:45 **Acute Urinary Retention: Do's and Dont's** — Dr. Persky.

4:00 **How We Can Be Fooled by Myxoedema** — Dr. Dobyns.

4:15 **What Has Surgery Accomplished for Myocardial Ischemia** — Dr. Pritchard.

4:30 **Polyneuritis: Its Diagnosis and Treatment** — Dr. Victor.

4:45 **Significance of Iron Deficiency Anemia** — Dr. Weisberger.

5:00 **Diagnostic Value of Rectal Valve Biopsy** — Dr. Abrams.

5:15 **Amputation for Vascular Disease: A Case for Conservatism** — Dr. Hopkins.

5:30 Adjournment.

WEDNESDAY, MAY 25

4:00 P. M. (D. S. T.)

OSMA Section for Hospital Directors of Medical Education

ORGANIZATIONAL MEETING

(Mohawk Room, First Floor)

5:00 P. M. (D. S. T.)

(Navajo Room, First Floor)

Reception sponsored by the Ohio State Medical Association for those Hospital Directors in attendance.

THURSDAY, MAY 26

8:30 A. M. (D. S. T.)

Film entitled: "A New Look at Tetanus Prophylaxis"

Shown by — Dr. Wesley Furste

Sponsored by Ohio Committee on Trauma, American College of Surgeons

(Gold Room, Mezzanine Floor)

THURSDAY, MAY 26

9:00 A. M. (D. S. T.)

Registration

(Grand Ballroom Foyer, Mezzanine Floor)

9:00 A. M. (D. S. T.)

Scientific, Health Education and Technical Exhibits

(Grand Ballroom and Ballroom Balcony)

THURSDAY, MAY 26

9:00 A. M. (D. S. T.)

Psychiatry and Neurology

(Grand Ballroom — Terrace, Parlor Floor)

Annual Meeting of the Ohio Psychiatric Association and OSMA Section on Psychiatry and Neurology.

THE PARTICIPANTS

Charles W. Harding, M. D., Worthington, Psychiatry, Harding Hospital, Inc.

Charles K. Hofling, M. D., Cincinnati, Assistant Professor of Psychiatry, University of Cincinnati College of Medicine.

Lothar B. Kalinowsky, M. D., New York, Flower and Fifth Avenue Hospitals, New York.

James J. Strain, M. D., Cleveland, University Hospitals.

Presiding: Dr. Hofling.

9:00 **Indoklon Shock Therapy** — Dr. Harding.
Discussant: Dr. Kalinowsky.

9:30 **Unilateral vs Bilateral ECT, A Double Blind Study** — Dr. Strain.
Discussant: Dr. Kalinowsky.

10:15 Recess for Tour of Exhibits.

10:45 **The Present Status of Somatic Therapies in Psychiatry** — Dr. Kalinowsky.

11:45 A. M. (D. S. T.)

Luncheon and Business Meeting of the Ohio Psychiatric Association

(Empire Room, Parlor Floor)

THURSDAY, MAY 26

9:00 A. M. (D. S. T.)

General Session

(Gold Room, Mezzanine Floor)

"Athletic Injuries"

Program presented by Ohio Committee on Trauma, American College of Surgeons; Joint Advisory Committee on Athletic Injuries of the OSMA, and the Ohio High School Athletic Association.



Dr. Quigley

THE PARTICIPANTS

Wesley Furste, M. D., Columbus, Member Subcommittee on Prophylaxis Against Tetanus of the National Committee on Trauma, American College of Surgeons.

Nicholas J. Giannestras, M. D., Cincinnati, Chairman, Section on Fractures and Orthopaedics, Good Samaritan Hospital, Cincinnati.

Robert J. Murphy, M. D., Columbus, Assistant Clinical Professor of Medicine at Ohio State University College of Medicine.

Richard Patton, M. D., Columbus, Assistant Clinical Professor of Surgery at Ohio State University College of Medicine.

T. B. Quigley, M. D., Boston, Mass., Clinical Professor of Surgery, Harvard Medical School.

Presiding: Thomas W. Morgan, M. D., Gallipolis, Chief, Section 5, Committee on Trauma, American College of Surgeons.

9:00 **Heat Stroke: Leading Cause of Death in Football** — Dr. Murphy.

9:30 **Common Ruptures of Ligaments, Tendons, and Muscles; Their Recognition and Treatment** — Dr. Quigley.

10:00 Intermission for Tour of Exhibits.

10:30 Problems Most Commonly Encountered by Team Physicians.
(Panel Discussion)
Moderator: Dr. Quigley.
Members of Panel: Drs. Giannestras, Patton and Murphy.

12:00 Adjournment.

THURSDAY, MAY 26

9:30 A. M. (D. S. T.)

Executive Sessions

RESOLUTIONS COMMITTEE NO. 1
(Wigwam Room, First Floor)

RESOLUTIONS COMMITTEE NO. 2
(Mohawk Room, First Floor)

RESOLUTIONS COMMITTEE NO. 3
(Chieftain Room, First Floor)

10:30 to 11:00 A. M. (D. S. T.)

Intermission for Tour of Exhibits

11:00 A. M. (D. S. T.)

Continuation of General Session and Scientific Section Meetings

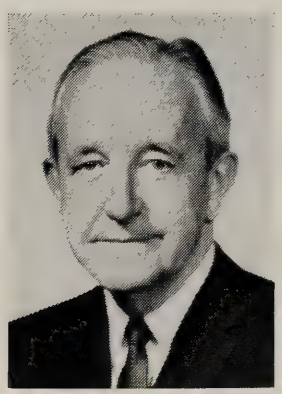
THURSDAY, MAY 26

1:30 P. M. (D. S. T.)

General Session

(Gold Room, Mezzanine Floor)

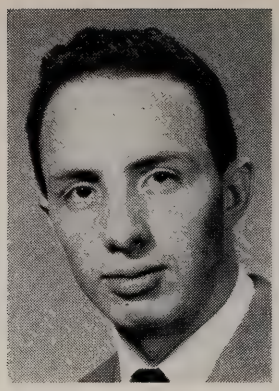
"Medicare's Rules and Regulations and Their Effect on the Practice of Medicine"



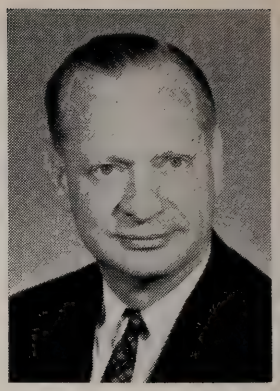
Dr. Hudson

Charles L. Hudson, M. D., Cleveland
President-Elect, American Medical Association

Dr. Hudson will present detailed information regarding the rules and regulations of Public Law 89-97 which becomes effective July 1, 1966. He has participated in the activities of the AMA's Task Force in its consultations with the Federal Government on the development of these rules and regulations. Dr. Hudson will answer questions from the audience following his formal presentation.



Dr. Aldrete



Dr. Phillips

THURSDAY, MAY 26

3:00 P. M. (D. S. T.)

Anesthesiology

(Terminal Room, Parlor Floor)
Program sponsored by the OSMA Section on Anesthesiology

THE PARTICIPANTS

J. Antonio Aldrete, M. D., Denver, Colorado, Instructor in Anesthesiology, University of Colorado.

John G. Fraser, M. D., Cleveland, Department of Anesthesiology, University Hospitals.

John P. Garvin, M. D., Columbus, Director of Anesthesiology, Columbus Children's Hospital.

Charles W. Hoyt, M. D., Cincinnati, Director, Department of Anesthesia, Bethesda Hospital.

David M. Katchka, M. D., Toledo, Director of Anesthesiology, Toledo Hospital.

Henry E. Kretchmer, M. D., Cleveland, Director of Department of Anesthesia, Cleveland Metropolitan General Hospital.

Otto C. Phillips, M. D., Pittsburgh, Pennsylvania, Professor of Anesthesiology, University of Pittsburgh School of Medicine.

Brant B. Sankey, M. D., Cleveland, Head, Department of Anesthesiology, St. Luke's Hospital.

John E. Steinhaus, M. D., Atlanta, Georgia, Professor and Chairman of Anesthesiology, Emory University School of Medicine.

3:00 **Anesthesia for Obstetrical Patients with Endocrine Disorders** — Dr. Kretchmer.

3:20 **Current Concepts in Obstetrical Anesthesia** — Dr. Phillips.

3:50 **Management of the Asthmatic Patient Under Anesthesia** — Dr. Aldrete.

4:05 **Endoscopy Revisited** — Dr. Hoyt.

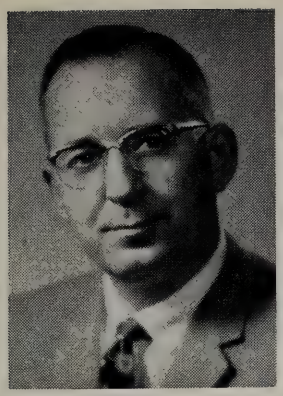
4:20 **The Anesthesiologist's Dilemma** — Dr. Steinhaus.

4:50 **Hyperpyrexia During and Following Anesthesia.** (Panel Discussion)

Moderator: Dr. Garvin; Members of Panel: Drs. Fraser, Katchka, and Sankey.

5:20 Election of Officers for 1967.

The foregoing program was arranged under the direction of the following: Nicholas G. DePiero, Cleveland, Chairman, and Edward Hartenian, M. D., Cincinnati, Secretary, Section on Anesthesiology.



Dr. Steinhaus



Dr. Feffer

THURSDAY, MAY 26

3:00 P. M. (D. S. T.)

Medical History

(Erie Room, Parlor Floor)

Annual Meeting of the Ohio Academy of Medical History

President: Bruno Gebhard, M. D., Cleveland

THE PARTICIPANTS

Dr. John J. Beeston, Cleveland

Ralph W. Dexter, Ph. D., Kent

Linden F. Edwards, Ph. D., Columbus

George R. L. Gaughran, Ph. D., Columbus

Kenneth I. E. MacLeod, M. D., M. P. H., Cincinnati

Cecil Striker, M. D., Cincinnati

3:00 Opening Session and Business Meeting.

3:30 Program.

Newspapers as Sources of the History of Medicine of Ohio — Dr. Edwards.

Ohio Contacts of Physicians Included in Hume's *Ornithologists of the U. S. Army Medical Corps* — Dr. Dexter.

The Stormy Career of G. S. Pattison — 19th Century Anatomist — Dr. Gaughran.

William E. Clendenning, M. D., First Health Officer of Cincinnati — Dr. MacLeod.

Subject to be announced — Dr. Striker.

6:00 P. M. (D. S. T.)

Cocktails and Dinner at the Howard Dittrick Museum of Historical Medicine, Cleveland Medical Library, 11000 Euclid Avenue.

After-Dinner Speaker — Dr. John J. Beeston, Director of the Cleveland Health Museum. **"1066 and All That"**

8:00 P. M. (D. S. T.)

Inspection of Rare Medical Books in the Cleveland Medical Library.

THURSDAY, MAY 26

3:00 P. M. (D. S. T.)

Internal Medicine

(Gold Room, Mezzanine Floor)

Program sponsored by the Section on Internal Medicine and the Ohio Society of Internal Medicine.

THE PARTICIPANTS

Albert A. Brust, M. D., Dayton, Associate Professor of Medicine, University of Cincinnati College of Medicine.

Harriet P. Dustan, M. D., Cleveland, Research Division, Cleveland Clinic Foundation.

James J. Feffer, M. D., Washington, D. C., Consultant to Division of Medical Care Administration, U. S. P. H. S.; Clinical Professor of Medicine and Chief of Pulmonary Disease Division, George Washington University School of Medicine.

Ray W. Gifford, Jr., M. D., Cleveland, Department of Hypertension and Renal Disease, Cleveland Clinic Foundation.

James F. Schieve, M. D., Columbus, Head of Renal Disease Division, Ohio State University College of Medicine.

Robert F. Williams, M. D., Cleveland, Associate Professor of Medicine, Western Reserve University School of Medicine.

Panel on Hypertension

Moderator: Dr. Gifford.

3:00 **Evaluation of the Hypertensive Patient** — Dr. Brust.

3:15 **Renovascular Hypertension** — Dr. Dustan.

3:30 **Management of Essential Hypertension** — Dr. Williams.

3:45 **Management of Hypertensive Crises** — Dr. Schieve.

3:55 Panel Discussion.

4:30 **Public Law, 89-97, Title XVIII** — Dr. Feffer.

5:15 Business Meeting and Election of Officers, OSMA Section on Internal Medicine and Ohio Society of Internal Medicine.

5:30 Adjournment.

The foregoing program was arranged under the direction of the following: William Bradley, M. D., Columbus, Chairman, and R. A. Van Ommen, M. D., Cleveland, Secretary, Section on Internal Medicine; John T. Grady, M. D., Cleveland, President, and Edward O. Hahn, M. D., Cleveland, Secretary-Treasurer, Ohio Society of Internal Medicine.

6:30 P. M. (D. S. T.)

Reception and Dinner, Ohio Society of Internal Medicine

(Grand Ballroom — Terrace, Parlor Floor)

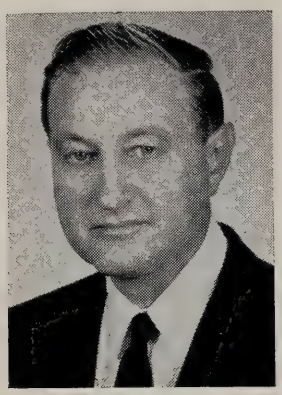
THURSDAY, MAY 26

3:00 P. M. (D. S. T.)

Psychiatry and Neurology

(Grand Ballroom — Terrace, Parlor Floor)

Program sponsored by the Section on Psychiatry and Neurology and the Ohio Psychiatric Association.



Dr. Goldfarb

THE PARTICIPANTS

Norman S. Brandes, M. D., Columbus, Teaching Consultant at Columbus State Hospital.

Alvin I. Goldfarb, M. D., New York, Consultant on Services for the Aged, New York State Department of Mental Hygiene.

James R. Hodge, M. D., Akron, Senior Staff and Chief of Psychiatry Section, Akron City Hospital.

W. Hugh Missildine, M. D., Columbus, Assistant Professor of Psychiatry at Ohio State University and Associate Professor of Pediatrics.

Howard P. Rome, M. D., Rochester, Minnesota, President, American Psychiatric Association, Chief, Department of Psychiatry, Mayo Clinic.

Presiding: Dr. Hodge.

3:00 **Contributions of Psychiatrists to the Care and Treatment of Aging by Other Physicians** — Dr. Goldfarb.

4:00 **A Dynamic Focus on School Phobias in Children and Adolescents** — Dr. Brandes.

Discussant: Dr. Missildine.

4:30 **Rapid Personality Evaluation in General Hospital Patients** — Dr. Rome.

The foregoing program was arranged under the direction of the following: W. Donald Ross, M. D., Cincinnati, President of Ohio Psychiatric Association and the Section on Psychiatry and Neurology; Philip Rond, M. D., Columbus, Secretary of Ohio Psychiatric Association and the Section on Psychiatry and Neurology, and J. Patrick Duffy, M. D., Cleveland, Program Chairman.

THURSDAY, MAY 26

3:00 P. M. (D. S. T.)

Ohio State Surgical Association

(Whitehall Room, Mezzanine Floor)

THE PARTICIPANTS

Theron L. Hopple, M. D., Toledo, Private Practice of Neurological Surgery.

Alfred W. Humphries, M. D., Cleveland, Head, Department of Vascular Surgery, Cleveland Clinic Foundation.

John C. Kelleher, M. D., Toledo, Director of Plastic Surgery, Maumee Valley and Mercy Hospitals of Toledo.

Thomas W. Morgan, M. D., Gallipolis, Holzer Clinic Staff.

3:00 **Mass Traumatic Disease—The Automobile** — Dr. Morgan.

3:30 **The Treatment of Head Injuries** — Dr. Hopple.

4:00 **Facial Trauma Associated with Automobile Accidents** — Dr. Kelleher.

4:30 **Arterial Trauma as a Result of Automobile Accidents** — Dr. Humphries.

6:30 P. M. (D. S. T.)

Ohio State Surgical Association

(Cleveland Room, Lobby Floor)

Cocktail Hour Followed by Banquet at 7:30 P. M.

(Open to other than members by preregistration)

Speaker: Thomas L. Dwyer, M. D., Mexico, Missouri
President of the American Association of Physicians and Surgeons.

10:30 P. M. (D. S. T.)

Ohio State Surgical Association

Board of Directors Hospitality Party

(Navajo Room, First Floor)

FRIDAY, MAY 27

7:30 A. M. (D. S. T.)

Woman's Auxiliary Breakfast for Physicians and Auxiliary Members

(Cleveland Room, Lobby Floor)

FRIDAY, MAY 27

9:00 A. M. (D. S. T.)

Registration

(Grand Ballroom Foyer, Mezzanine Floor)

FRIDAY, MAY 27

9:00 A. M. (D. S. T.)

Scientific, Health Education and Technical Exhibits

(Grand Ballroom and Ballroom Balcony)

FRIDAY, MAY 27

9:00 A. M. (D. S. T.)

House of Delegates Final Business Session

(Gold Room, Mezzanine Floor)

Roll Call of Delegates.

Introduction of honored guests.

Consideration of unfinished business.

Reports of Reference Committees:

President's Address
Resolutions

Election of President-Elect.

Report of Committee on Nominations:

(a) Nominations for The Council.
(Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.) To be elected:

First District — (Incumbent, Robert E. Howard, M. D., Cincinnati.)

Third District — (Incumbent, Frederick T. Merchant, M. D., Marion.)

Fifth District — (Incumbent, P. John Robechek, M. D., Cleveland.)

Seventh District — (Incumbent, Benjamin C. Diefenbach, M. D., Martins Ferry.) NOTE: Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and Bylaws of the Association.

Ninth District — (Incumbent, George N. Spears, M. D., Ironton.)

Eleventh District — (Incumbent, William R. Schultz, M. D., Wooster.)

(b) Election of Delegates and Alternates to the American Medical Association — four Delegates and four Alternates to be elected, each for a two-year term starting, January 1, 1967, in compliance with the Constitution and Bylaws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1966 and they may be considered by the nominating committee for re-election for two-year terms starting January 1, 1967.

Theodore L. Light, M. D., Dayton
(Delegate)

Kenneth D. Arn, M. D., Dayton
(Alternate)

Carl A. Lincke, M. D., Carrollton
(Delegate)

Robert S. Martin, M. D., Zanesville
(Alternate)

George W. Petznick, M. D., Cleveland
(Delegate)

Horatio T. Pease, M. D., Wadsworth
(Alternate)

Edmond K. Yantes, M. D., Wilmington
(Delegate)

Harry K. Hines, M. D., Cincinnati
(Alternate)

Due to increased AMA membership, the Ohio State Medical Association is eligible to elect a tenth Delegate and a tenth Alternate Delegate to the American Medical Association. It will be necessary to select a Delegate and an Alternate Delegate for a partial term ending December 31, 1966, and a Delegate and an Alternate Delegate for the two year term beginning on January 1, 1967.

Installation of Officers for 1966-1967.

Submission of Committee appointments by the new President for confirmation by the House of Delegates.

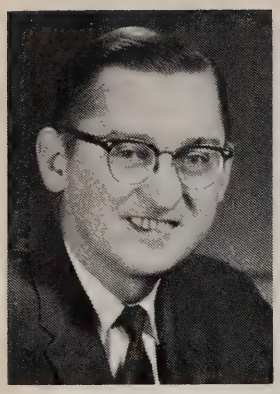
Unfinished or new business.

Adjournment.

12:00 NOON (D. S. T.)

(Whitehall Room, Mezzanine Floor)

Complimentary Luncheon for Delegates, Alternate Delegates and OSMA Council.



Dr. Tomashefski

FRIDAY, MAY 27

9:00 A. M. - 12 NOON

Medical Booth Seminars

(Exhibit Hall Area)

These one-half hour booth seminar presentations will present practical demonstrations of equipment and procedures that may be used in everyday practice. As you will note, three of the presentations will be running simultaneously beginning at 9:00, 10:00 and 11:00. The other three beginning at 9:30, 10:30 and 11:30. It is hoped that physicians will have an opportunity to view all of the presentations.

Starting time: 9:00, 10:00 and 11:00 A. M.

BOOTH NO. 1 — "Conditioning, Prevention and First Aid for Athletic Injuries"

Mr. Ernest R. Biggs, Columbus, Head Athletic Trainer, Ohio State University. Chairman of Committee on Injuries, National Athletic Trainers Association; Member, Committees on Competitive Safeguards and Medical Aspects of Sports; National Collegiate Athletic Association.



Dr. Kennedy

BOOTH NO. 3 — "Bedside Pulmonary Function Testing"

Joseph F. Tomashefski, M. D., Columbus, Assistant Professor of Medicine and Associate Professor of Preventive Medicine and Physiology, O. S. U. College of Medicine and Chief of Research and Director of Cardiopulmonary Laboratories, Ohio Tuberculosis Hospitals.



Dr. Johnson

BOOTH NO 5 — "Physical Medicine in the Home"

Ernest W. Johnson, M. D., Columbus, Professor and Chairman of the Department of Physical Medicine, The Ohio State University College of Medicine.

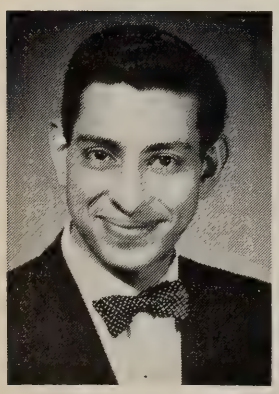
Starting time: 9:30, 10:30 and 11:30 A. M.

BOOTH NO. 2 — "Resuscitation"

John H. Kennedy, M. D., Cleveland, Surgeon-in-charge of thoracic surgical services, Cleveland Metropolitan General Hospital and Assistant Professor of Thoracic Surgery, Western Reserve University.

John Homi, M. D., Cleveland, Department of Anesthesiology, Cleveland Clinic Foundation.

Henry E. Kretchmer, M. D., Cleveland, Associate Professor of Anesthesiology, Western Reserve University School of Medicine; Director, Department of Anesthesiology at Cleveland Metropolitan General Hospital.



Dr. Homi

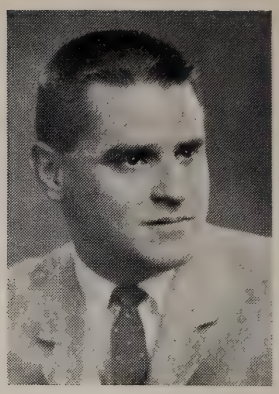
BOOTH NO. 4 — "Lacerations"

H. W. Porterfield, M. D., Columbus, Instructor, Department of Surgery, Ohio State University College of Medicine, Private Practice of Plastic Surgery.

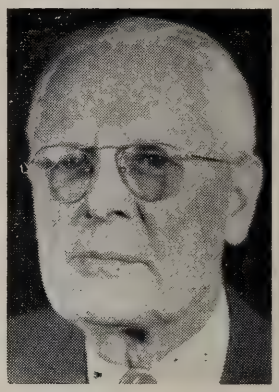
S. W. Hartwell, Jr., M. D., Cleveland, Department of Plastic Surgery, Cleveland Clinic Foundation.

Donald M. Glover, M. D., Cleveland, Clinical Professor of Surgery, Emeritus, Western Reserve University School of Medicine.

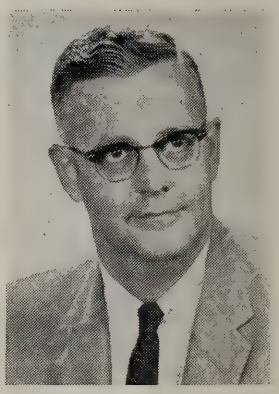
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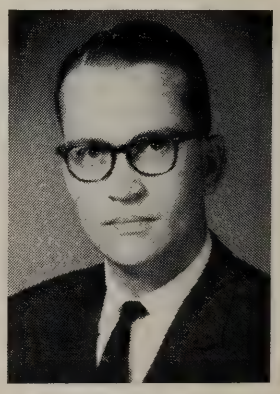
Dr. Porterfield



Dr. Glover



Dr. Brown



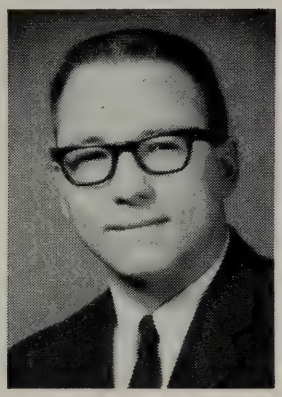
Dr. Hartwell

(Medical Booth Seminars — Contd.)

BOOTH NO. 6 — "Fractures"

Charles M. Evarts, M. D., Cleveland, Staff, Department of Orthopedic Surgery, Cleveland Clinic Foundation.

Kent L. Brown, M. D., Cleveland, Assistant Surgeon, St. Luke's Hospital.



Dr. Evarts

FRIDAY, MAY 27

11:00 A. M. (D. S. T.)

Ohio State Surgical Association

Business Meeting and Installation of Officers

(Terminal Room, Parlor Floor)

12:00 P. M.

New President's Luncheon with Senior Members Honored

(Navajo Room, First Floor)

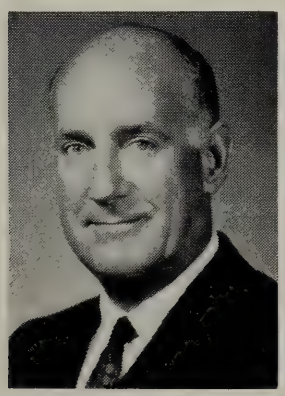
FRIDAY, MAY 27

1:30 P. M. (D. S. T.)

General Session

(Gold Room, Mezzanine Floor)

"Care of the Patient: 1966"



Dr. Annis

Edward R. Annis, M. D., Miami, Florida
Past President, American Medical Association

Dr. Annis will make his presentation on the theme of the 1966 OSMA Annual Meeting. He will look at the future of patient care and the effect of various pieces of Federal legislation upon the traditional physician-patient relationship. A question and answer period will follow Dr. Annis' formal presentation.

FRIDAY, MAY 27

1:00 P. M. (D. S. T.)

Orthopaedic Surgery

(Lewis Room, Lobby Floor)

Program sponsored by the Section on Orthopaedic Surgery and the Ohio Orthopaedic Society



Dr. Curtis

THE PARTICIPANTS

Burr H. Curtis, M. D., Newington, Conn., Medical Director, Newington Hospital for Children.

Barry A. Friedman, M. D., Cleveland, Assistant Clinical Professor of Orthopaedic Surgery, Western Reserve University School of Medicine.

F. W. Rhinelander, M. D., Professor of Orthopaedic Surgery, Western Reserve University School of Medicine; Chief, Orthopaedic Service, Cleveland Metropolitan General Hospital.

James T. Hartman, M. D., Cleveland, Orthopaedic Surgery, Staff member, Cleveland Clinic and Hospital.

1:00 Registration.

2:30 **Correlation of Cine-Roentgenography and Cervical Spine Injuries** — Dr. Hartman.

2:55 **Ultrastructural Changes in Osteogenic Sarcoma** — Dr. Friedman.

3:20 **Neurofibromatosis with Paralysis** — Dr. Curtis.

4:30 **Internal Fixation and Healing of Fractures** — Dr. Rhinelander.

5:00 First Executive Session of the Ohio Orthopaedic Society; and Election of OSMA Section Officers for 1967.

The foregoing program was arranged under the direction of the following: Norman J. Rosenberg, M. D., Cleveland, John Q. Brown, M. D., Columbus, officers of the Section on Orthopaedic Surgery and the Ohio Orthopaedic Society; Thomas F. Linke, M. D., Lakewood, and J. George Furey, M. D., Willoughby, cochairman, Program Committee.

6:30 P. M. (D. S. T.)

Orthopaedic Surgery

(Grand Ballroom — Terrace, Parlor Floor)

Cocktails and Banquet

FRIDAY, MAY 27

2:30 P. M. (D. S. T.)

Intermission for Tour of Exhibits

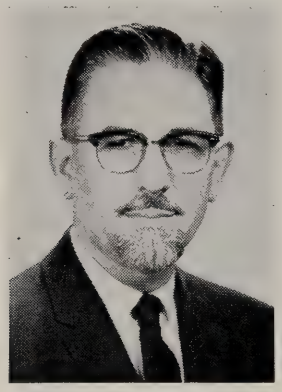
FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

General Practice of Medicine Obstetrics and Gynecology Pediatrics

(Gold Room, Mezzanine Floor)

Program sponsored by the Sections on General Practice of Medicine, Obstetrics and Gynecology, Pediatrics, and Ohio Chapter, American Academy of Pediatrics



Dr. Huffman

THE PARTICIPANTS

A. Scott Dowling, M. D., Cleveland, Instructor in Child Psychiatry, Western Reserve University School of Medicine.

John W. Huffman, M. D., Chicago, Illinois, Professor, Department of Obstetrics and Gynecology, Northwestern University Medical School.

Roger B. Scott, M. D., Cleveland, Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine.

Earl E. Smith, M. D., Cleveland, Assistant Clinical Professor of Pediatrics, Western Reserve University School of Medicine.

Samuel Spector, M. D., Cleveland, Professor of Pediatrics, Western Reserve University School of Medicine.

Presiding: Dr. Spector.

Pediatric Gynecology

3:00 **Kindergarten Gynecology: Some Common Gynecological Problems in Childhood** — Dr. Huffman.

3:50 Recess.

4:00 **Pediatric Gynecology** (Panel Discussion).
Moderator: Dr. Spector.
Members of Panel: Drs. Dowling, Huffman, Scott and Smith.

5:15 Election of Officers for 1967.

5:30 Adjournment.

The foregoing program was arranged under the direction of the following: Thomas M. Hughes, M. D., Columbus, Chairman, William M. Wilson, M. D., Columbus, Secretary, Section on General Practice of Medicine; Lester A. Ballard, M. D., Cleveland, Chairman, Sidney Kay, M. D., Cincinnati, Secretary, Section on Obstetrics and Gynecology; Chester T. Kasmersky, M. D., Columbus, Chairman, Henry Saunders, M. D., Cleveland, Secretary, Section on Pediatrics; Samuel Spector, M. D., Cleveland, President, Northern Ohio Pediatric Society.

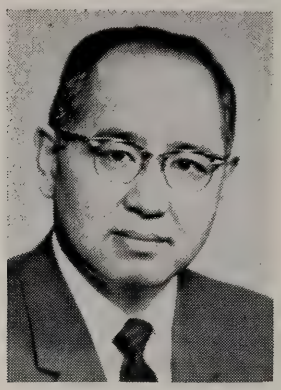
FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

Ear, Nose and Throat

(Terminal Room, Parlor Floor)

Program sponsored by the Section on Ear, Nose and Throat and the Ohio Ear, Nose and Throat Society



Dr. Ogura

THE PARTICIPANTS

Richard B. Fleming, M. D., Cincinnati.

Joseph H. Ogura, M. D., St. Louis, Missouri, Professor of Otolaryngology, Washington University School of Medicine.

Michael M. Paparella, M. D., Columbus, Assistant Professor, Department of Otolaryngology, Ohio State University College of Medicine.

Richard L. Ruggles, M. D., Cleveland, Senior Clinical Instructor of Otolaryngology.

3:00 **Tympanic Perforations — Safe or Not** — Dr. Ruggles.

3:20 Open Discussion.

3:30 **Modern Management of Facial Fractures** — Dr. Fleming.

3:50 Open Discussion.

4:00 **Functions of a Deafness Research Foundation Laboratory** — Dr. Paparella.

4:20 Open Discussion.

4:30 **Preoperative Radiation for Malignant Tumors of the Head and Neck**—Dr. Ogura.

5:00 Open Discussion.

5:15 Election of Officers for 1967.

5:30 Adjournment.

6:45 P. M. (D. S. T.)
(Terminal Room, Parlor Floor)

Ohio Ear, Nose and Throat Society

Cocktails followed by dinner at 7:30 P. M.

"Amusing Experiences in Laryngology Over the Years"

Joseph H. Ogura, M. D., St. Louis, Missouri

The foregoing program was arranged under the direction of the following: Charles E. Kinney, M. D., Cleveland, Chairman of the Section on Ear, Nose and Throat and President of the Ohio Ear, Nose and Throat Society; Stephen P. Hogg, M. D., Secretary, Cincinnati, Section on Ear, Nose and Throat and Secretary of the Ohio Ear, Nose and Throat Society.

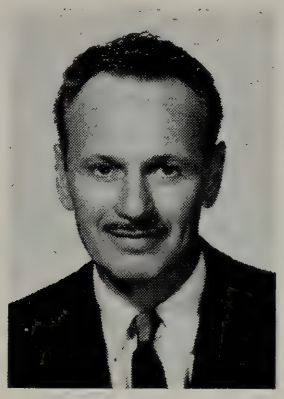
FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

Physical Medicine and Rehabilitation

(Navajo Room, First Floor)

Program sponsored by the Section on Physical Medicine and Rehabilitation and the Ohio Society of Physical Medicine and Rehabilitation



Dr. Cailliet

THE PARTICIPANTS

Rene Cailliet, M. D., Los Angeles, California, Associate Professor of Physical Medicine and Rehabilitation, University of Southern California School of Medicine.

John S. Collis, M. D., Cleveland, Department of Physical Medicine, Cleveland Clinic.

Ernest W. Johnson, M. D., Columbus, Professor and Chairman, Department of Physical Medicine, Ohio State University College of Medicine.

Karl J. Olsen, M. D., Cleveland, Department of Physical Medicine, Cleveland Clinic.

3:00 **Problems of Back Pain for the General Practitioner and the Specialist** — Dr. Cailliet.

3:40 **Contribution of Discography to Delineation of Low Back Pains** — Dr. Collis.

4:00 **Electrodiagnostic Tests and the Problem of Back Pain** — Dr. Olsen.

4:20 **What is Adequate Conservative Therapy?** — Dr. Johnson.

4:40 Panel Discussion.
Members of Panel: Drs. Cailliet, Collis, Johnson and Olsen.

5:00 Election of Officers for 1967.

The foregoing program was arranged under the direction of the following: Karl J. Olsen, M. D., Cleveland, Chairman, Marvin H. Spiegel, M. D., Columbus, Secretary, Section on Physical Medicine and Rehabilitation; John D. Guyton, M. D., Worthington, President, Robert J. Gosling, M. D., Toledo, Secretary, Ohio Society of Physical Medicine and Rehabilitation.

8:00 P. M. (D. S. T.)

(Navajo Room, First Floor)

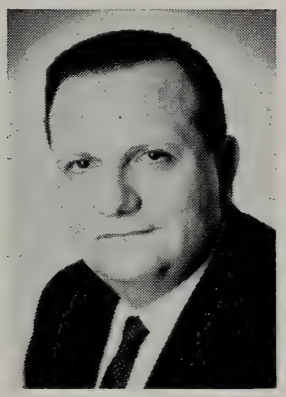
Dinner, Ohio Society of Physical Medicine and Rehabilitation

FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

Occupational Medicine

(Erie Room, Parlor Floor)



Dr. Warshaw

THE PARTICIPANTS

Harold R. Imbus, M. D., Marion, Department of Occupational Medicine, Marion General Hospital.

Leon J. Warshaw, M. D., New York, N. Y., Medical Director, Paramount Pictures Corporation and United Artists Corporation.

3:00 **Work and Coronary Heart Disease** — Dr. Warshaw.

3:45 Question and Answer Period.

4:00 Intermission for Tour of Exhibits.

4:10 **Help Wanted: Part-Time Physicians for Industry** — Dr. Imbus.

4:55 Election of Officers for 1967.

5:10 Adjournment.

The foregoing program was arranged under the direction of the following: Lee H. Miller, M. D., Cincinnati, Chairman; W. W. Davis, M. D., Columbus, Secretary, Section on Occupational Medicine.

FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

Pathology

(Cleveland Room, Lobby Floor)

Program sponsored by the Section on Pathology and the Ohio Society of Pathologists

THE PARTICIPANT

James W. Reagan, M. D., Cleveland, Professor of Pathology, Western Reserve University School of Medicine.

3:00 **Slide Seminar on Ovarian Tumors** — Dr. Reagan.

5:30 Business Meetings of Section on Pathology and the Ohio Society of Pathologists.

6:30 Adjournment.

The foregoing program was arranged under the direction of the following: Colin R. Macpherson, M. D., Columbus, and L. J. McCormack, M. D., Cleveland, Chairman and Secretary, respectively, Section on Pathology and the Ohio Society of Pathologists.

8:00 P. M. (D. S. T.)

Banquet, Ohio Society of Pathologists

(Erie and Empire Rooms, Parlor Floor)

FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

Neurological Surgery

(Empire Room, Parlor Floor)

Program sponsored by the Section on Neurological Surgery and the Ohio Neurosurgical Society



Dr. Shy

THE PARTICIPANTS

Robert C. Atkinson, M. D., Columbus.

Thomas E. Brown, M. D., Cincinnati.

Robert L. McLaurin, M. D., Cincinnati, Director of Division of Neurosurgery, University of Cincinnati College of Medicine.

Richard H. Retter, M. D., Columbus, Instructor of Neurosurgery, Ohio State University College of Medicine.

Warren H. Leimbach, M. D., Columbus, Instructor of Neurosurgery, Ohio State University College of Medicine, Consultant, V. A. and Crippled Children's Society.

Martin P. Sayers, M. D., Chief of Neurosurgery, Children's Hospital, Columbus.

George Milton Shy, M. D., Philadelphia, Pa., Professor of Neurology and Chairman, Department of Neurology, University of Pennsylvania School of Medicine.

3:00 **New Disclosures on the Causes of Muscular Weakness** — Dr. Shy.

4:00 **Experiences with Basal Artery Aneurysms** — Drs. Retter, Leimbach and Atkinson.

Effects of Laser Energy on Central Nervous System Tissue — Drs. McLaurin and Brown.

Reduction Cranipolasty — Dr. Sayers.

5:00 Election of Officers for 1967.

5:30 Adjournment.

The foregoing program was arranged under the direction of the following: Laurence M. Weinberger, M. D., Akron, and George H. Hoke, M. D., Lorain, Chairman and Secretary, respectively, Section on Neurological Surgery and the Ohio Neurosurgical Society.

FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

Ohio Chapter, American College of Chest Physicians Section on Radiology

(Whitehall Room, Mezzanine Floor)

Program sponsored by the Ohio Chapter of the American College of Chest Physicians and the Section on Radiology

THE PARTICIPANTS

Neil C. Andrews, M. D., Columbus, Associate Professor of Thoracic Surgery, Ohio State University College of Medicine.

F. Mason Jones, Jr., M. D., Cleveland, Department of Surgery, Cleveland Clinic.

Abbas M. Rejali, M. D., Cleveland, Assistant Professor of Radiology, Western Reserve University School of Medicine.

Frederick A. Rose, M. D., Cleveland, Associate Professor of Radiology, Western Reserve University School of Medicine.

3:00 **Lung Scanning with Macro-aggregated Human Albumin Serum** — Dr. Rejali.

3:25 Discussion.

3:30 **Palliative Treatment of Primary and Metastatic Carcinoma of the Lung** — Dr. Andrews.

3:55 Discussion.

5:00 Election of Officers for 1967.

5:30 Adjournment.

The foregoing program was arranged under the direction of the following: Jane P. McCullough, M. D., Cleveland, President, John L. Friedman, M. D., Cincinnati, Secretary-Treasurer, Ohio Chapter, American College of Chest Physicians; Frederick A. Rose, M. D., Cleveland, Chairman, and Benjamin F. Jackson, Cleveland, Secretary, Section on Radiology.

FRIDAY, MAY 27

3:00 P. M. (D. S. T.)

All Exhibits May Be Dismantled

FRIDAY, MAY 27

6:00 P. M. (D. S. T.)

OSMA President's Reception

(Whitehall and Gold Rooms, Mezzanine Floor)

You are Invited...

TO ATTEND

THE PRESIDENT'S RECEPTION

FRIDAY, MAY 27
6:00 to 8:00 P. M.

GOLD AND WHITEHALL ROOMS
Sheraton-Cleveland Hotel

SOCIAL HIGHLIGHT OF THE 1966 ANNUAL MEETING



A congenial get-together where members, their ladies and guests may gather for refreshments, dancing and the atmosphere of a social period.

NO SPEECHES — NO FORMAL PROGRAM
DRESS: OPTIONAL

Hors D'Oeuvres
Compliments of the Association
Cash Bar Will Be Open

Several specialty societies have planned dinners on this evening, beginning at 7:00, 7:30 or 8:00 p. m. Other members and guests will have ample time to dine at one of Cleveland's fine restaurants.



Dance to . . .
The Bob Lorence Orchestra
featuring
Salli Lynn
Vocalist



SATURDAY, MAY 28

9:00 A. M. (D. S. T.)

Registration

(Grand Ballroom Foyer)

9:00 A. M. (D. S. T.)

Conference on Laboratory Medicine

(Gold Room, Mezzanine Floor)

Program sponsored by the Committee on Laboratory Medicine of the Ohio State Medical Association.

THE PARTICIPANTS

John W. King, M. D., Cleveland, Clinical Pathologist at Cleveland Clinic.

C. R. Macpherson, M. D., Columbus, Assistant Professor, Department of Pathology and Chief Division of Bacteriology, Ohio State University Medical Center.

Samuel Meites, Ph. D., Columbus, Biochemist, Children's Hospital.

Leonard Skeggs, Ph. D., Cleveland.

Charles E. Willis, M. D., Cleveland.

D. M. Young, M. D., Ph. D., Toronto, Ontario, Canada, Director of Laboratories, Toronto General Hospital.

Presiding: Horace B. Davidson, M. D., Columbus, Chairman, Committee on Laboratory Medicine, Ohio State Medical Association.

9:00 **Multiphasic Screening with Autoanalyzer** — Dr. Skeggs.

9:45 **Unsolicited Laboratory Information: Its Effect on Patients and Their Physicians** — Dr. Young.

10:30 Discussion.

10:45 Break.

11:00 **Serologic Procedures in Relation to Amniocentesis** — Dr. Macpherson.

11:15 Discussion.

11:20 **Studies on Pigments in the Amniotic Fluids** — Drs. Willis and King.

11:35 Discussion.

11:40 **Problems in the Estimation of Serum Bilirubin in the Newborn** — Dr. Meites.

11:55 Discussion.

12:00 Adjournment.

The foregoing program was arranged under the direction of the following members of the Committee on Laboratory Medicine of the Ohio State Medical Association: Horace B. Davidson, M. D , Columbus, Chairman; William H. Benham, M. D., Columbus; John B. Hazard, M. D., Cleveland; Melvin Oosting, M. D., Dayton; Arthur E. Rappoport, M. D., Youngstown; Philip B. Wasserman, M. D., Cincinnati; William Sinclair, M. D., Cleveland; and Gilbert B. Stansell, M. D., Toledo.

SATURDAY, MAY 28

12:00 NOON (D. S. T.)

Organizational Meeting, Ohio Association of Blood Banks

(Gold Room, Mezzanine Floor)

SATURDAY, MAY 28

9:00 - 12:00 NOON (D. S. T.)

Clinical Conference

Sponsored by the Ohio Chapter, American Academy of Pediatrics
(Babies and Childrens Hospital)

12:00 NOON (D. S. T.)

OSMA Annual Meeting Closes

SATURDAY, MAY 28

12:00 - 12:30 P. M. (D. S. T.)

Annual Meeting Ohio Chapter, American Academy of Pediatrics

(Babies and Childrens Hospital)

Jefferson Medical Alumni Reunion Scheduled Thursday, May 26

A get-together has been arranged for the alumni of Jefferson Medical College, their wives and guests who will be in attendance at the 1966 Annual Meeting of the Ohio State Medical Association in Cleveland, May 24 - 28. This will be the 15th annual dinner meeting of the Ohio group.

The meeting is to be held in the Terminal Room, Parlor Floor, of the Sheraton-Cleveland Hotel, Thursday, May 26. Activities will commence with a "fellowship hour" at 6:30 p. m., followed by dinner at 7:30 p. m., and "Brief Speeches" by representatives from Alma Mater at 8:30 p. m. Alumni and guests are urged to attend **any** portion of the program that fits their schedule. However, it is important that those planning to attend dinner, secure reservations **in advance,** by sending a card or note to: Russell S. McGinnis, M. D., '21, Jefferson Dinner Chairman, 10515 Carnegie Avenue, Cleveland, Ohio 44106. Tickets may be purchased at the door on Thursday, May 26.

Ohio Health Commissioners' Institute, Cleveland

May 25 - 27, 1966

To Be Held in Conjunction with the Ohio State Medical Association Annual Meeting

Sheraton-Cleveland Hotel, Cleveland

(All Events on Daylight Saving Time)

WEDNESDAY, MAY 25

10:00 A. M. OSMA Registration Opens. (Grand Ballroom Foyer, Mezzanine Floor)

12:00 - 1:00 P. M. Lunch Break.

1:00 - 2:00 P. M. Greetings and Progress Reports on Program Activities—Emmett W. Arnold, M. D., Director of Health. (Grand Ballroom — Terrace, Parlor Floor)

FIRST SESSION

2:00 - 5:00 P. M. "Epidemiology of Accidents." (Grand Ballroom — Terrace, Parlor Floor)

Presiding — Donald Day, Engineer in Charge, Accident Prevention Unit, Division of Engineering, Ohio Department of Health.

The Prevention of Injuries and the Federal Government's Role — Robert L. Price, M. D., Assistant Chief, Division of Accident Prevention, United States Public Health Service, Washington, D. C.

3:15 - 3:45 P. M. Tour of Exhibits.

The Role of the Physician in Accident Prevention — Robert E. Reiheld, M. D., Orrville, Ohio.

THURSDAY, MAY 26

SECOND SESSION

9:00 - 12:00 NOON "Adolescence." (Lewis Room, Lobby Floor)

Presiding — T. A. Gardner, M. D., Chief, Bureau of Local Services, Ohio Department of Health.

Developmental Aspects of the Adolescent Years — Effie O. Ellis, M. D., Region V, Children's Bureau, Chicago, Illinois.

10:15 - 10:45 A. M. Tour of Exhibits.

Panel: Effie O. Ellis, M. D., Moderator; panel members consist of a pediatrician, school psychologist, teacher of adolescents, and a psychiatrist.

12:00 - 1:30 P. M. Lunch Break.

THIRD SESSION

3:00 - 5:00 P. M. "Rehabilitation." (Lewis Room, Lobby Floor)

Presiding — Aileen L. MacKenzie, M. D., Chief, Division of Chronic Diseases, Ohio Department of Health.

Rehabilitation Needs — Harry D. Bouman, M. D., Professor of Physical Medicine and Rehabilitation, School of Medicine, University of Cincinnati, Cincinnati, Ohio.

Strokes — A Public Health Problem — Amasa B. Ford, M. D., Medical Director, Benjamin Rose Hospital, Cleveland.

6:00 - 7:00 P. M. Reception for Health Commissioners (Erie Room, Parlor Floor)

7:00 P. M. Health Commissioners' Banquet. (Erie and Empire Rooms, Parlor Floor)

Robert H. Hutcheson, M. D., M. P. H., Commissioner, Department of Public Health, State of Tennessee, Nashville, Tennessee.

FRIDAY, MAY 27

FOURTH SESSION

8:30 - 12:00 NOON "Current Communicable Disease Concerns." (Lewis Room, Lobby Floor)

Presiding — Calvin B. Spencer, M. D., Acting Chief, Division of Communicable Diseases, Ohio Department of Health.

The Control of Venereal Diseases — M. Brittain Moore, Jr., M. D., Dermatologist, Lakeland, Florida. Formerly Director of Venereal Disease Research Laboratory, Venereal Disease Branch, Communicable Disease Center, United States Public Health Service, Atlanta, Georgia.

10:00 - 10:30 Tour of Exhibits.

Ohio Control Program — George Sides, Venereal Disease Program Representative, Chief, Venereal Disease Section, Division of Communicable Diseases, Ohio Department of Health.

Arthropod-Borne Encephalitides—The National Situation — Telford H. Work, M. D., Chief, Virology Section, Laboratory Branch, Communicable Disease Center, United States Public Health Service, Atlanta, Georgia.

The Ohio Study — Ralph A. Masterson, D. V. M., M. P. H., Epidemiologist, Division of Communicable Diseases, Ohio Department of Health.

12:00 NOON Ohio Health Commissioners' Institute Adjourns.

Twenty-Sixth Annual Convention

of the

Woman's Auxiliary to the Ohio State Medical Association

May 24 - 27, 1966 — Sheraton-Cleveland Hotel

Hospitality Room
(Main Lobby West)
Wednesday, May 25 ..... 8:30 A. M. - 4:00 P. M.
Thursday, May 26 ..... 8:30 A. M. - 4:00 P. M.

Registration and Information Schedule
(Main Lobby West)
Tuesday, May 24 .....10:00 A. M. - 4:00 P. M.
Wednesday, May 25 ..... 8:30 A. M. - 4:00 P. M.
Thursday, May 26 ..... 8:30 A. M. - 4:00 P. M.
Friday, May 27 ..... 8:30 A. M. - 1:30 P. M.

CONVENTION PROGRAM

Tuesday, May 24

10:00 A. M. - 12:00 NOON Budget and Finance Committee (Teepee Room, First Floor)

11:00 - 12:00 Resolutions Committee (Wigwam Room, First Floor)

1:30 - 5:00 P. M. Preconvention Board Meeting (Navajo Room, First Floor)

6:00 P. M. Reception and Dinner for State Board Members (Long Hut - Kon Tiki Restaurant)

Wednesday, May 25

9:00 - 11:30 A. M. First Business Session (Cleveland Room, Lobby Floor)

11:30 A. M. - 12:00 NOON Social Hour (Gold Room Foyer, Mezzanine Floor)

12:00 NOON - 1:15 P. M. OMPAC Luncheon (Gold Room, Mezzanine Floor)

1:30 - 2:30 P. M. OSMA General Session (Cleveland Room, Lobby Floor) "Problems in Marriage"

3:00 - 5:00 P. M. County Reports (Cleveland Room, Lobby Floor)

5:30 - 7:30 P. M. Hixon's Barn (transportation provided)

6:30 P. M. Gavel Club Dinner (Parlor 32, Parlor Floor)

Thursday, May 26

9:00 - 11:15 A. M. Second Business Session (Cleveland Room, Lobby Floor)

11:30 A. M. - 12:00 NOON Social Hour (Courtesy of Tuscarawas County Auxiliary) (Whitehall Room, Mezzanine Floor)

12:00 NOON - 1:15 P. M. Luncheon (Honoring Past Presidents and County Presidents — Hosted by Lake County (Whitehall Room, Mezzanine Floor)

1:30 - 2:30 P. M. OSMA General Session Charles L. Hudson, M. D., President-Elect, AMA (Gold Room, Mezzanine Floor)

3:00 - 5:00 P. M. School of Instruction (Cleveland Room, Lobby Floor)

3:00 - 5:30 P. M. Voting (Mezzanine Lobby East)

5:30 - 7:30 P. M. Hixon's Barn (transportation provided)

Friday, May 27

7:30 - 8:45 A. M. Woman's Auxiliary Breakfast for Members and Physicians (Cleveland Room, Lobby Floor)

9:30 A. M. - 12:00 NOON Third Business Session, Installation of Officers (Cleveland Room, Lobby Floor)

12:00 NOON - 12:20 P. M. Happy Time (Cleveland Room, Lobby Floor)

12:20 - 1:00 P. M. Lunch-on-a-Cart (In Honor of New Officers, Members and Honored Guests) (Cleveland Room, Lobby Floor)

1:30 - 2:30 P. M. OSMA General Session, "Care of the Patient: 1966, "Edward R. Annis, M. D., Past President, AMA (Gold Room, Mezzanine Floor)

3:00 - 4:30 P. M. Post-Convention Board Meeting (Parlor 34, Parlor Floor)

6:00 - 8:00 P. M. OSMA President's Reception (Gold and Whitehall Rooms, Mezzanine Floor)

Convention Committee Chairmen

Convention — Mrs. Burdett Wylie
Convention Cochairman — Mrs. Roscoe J. Kennedy
Registration — Mrs. James A. Gavin
Registration Cochairman — Mrs. F. M. Freimann
Hospitality Lounge—Mrs. John J. Grady

SCIENTIFIC AND HEALTH EDUCATION EXHIBIT

The Scientific and Health Education Exhibit will be open from 10:00 A. M. to 5:30 P. M. on Wednesday, May 25; from 9:00 A. M. to 5:30 P. M. on Thursday, May 26; and from 9:00 A. M. to 3:00 P. M. on Friday, May 27, Daylight Saving Time.

Listed below are the Scientific and Health Education Exhibit applications which were approved at the March 3 meeting of the Committee on Scientific and Health Education Exhibit.

SCIENTIFIC EXHIBITS

(Grand Ballroom Balcony)

S-85 — **Phenylketonuria**

Emmett W. Arnold, M. D., Director of Ohio Department of Health, Columbus.

S-86 — **Evaluation of Analgesics and a New Episiotomy Procedure in Relief of Postpartum Pain and Trauma**

Ralph C. Benson, M. D., Raphael B. Durfee, M. D., J. Morton Schneider, M. D., University of Oregon Medical School, Portland, Oregon.

S-87 — **Practical Treatment of Musculoskeletal Disorders**

Fred J. Phillips, M. D., C. L. Chai, M. D., M. D. Debuque, M. D., David M. Shoemaker, M. D., Quakertown, Pennsylvania.

S-88 — **Conserve Vision—Detect Glaucoma**

Clifford H. Cole, M. D., Neurological and Sensory Disease Service Program, U. S. Public Health Service, Washington, D. C.

S-89 — **Mechanical Support for the Failing Heart**

John H. Kennedy, M. D., and Nicholas Bailas, M. D., Cleveland Metropolitan General Hospital and Western Reserve University School of Medicine, Cleveland.

S-90 — **Surgical Management of Priapism**

Chester C. Winter, M. D., F.A.C.S., Division of Urology, Ohio State University Hospital, Columbus.

S-91 — **Mechanical Occlusion of the Vertebral Artery**

E. A. Husni, M. D., H. S. Bell, M. D., and John Storer, M. D., Huron Road Hospital, Cleveland.

S-92 — **Pancreatic Scan**

A. R. Antunez, M. D., E. J. Filson, M. D., S. O. Hoerr, M. D., R. E. Hermann, M. D., C. H. Brown, M. D., B. H. Sullivan Jr., M. D., and F. J. Owens, M. D., Cleveland Clinic Foundation, Cleveland.

S-93 — **A Modified Technique for ODDI Sphincterectomy—An Expanding Abdominal Retractor**

Michael Meftah, M. D., Madison County Hospital, London.

S-94 — **Bilateral Transabdominal, Transperitoneal Omentoureterostomy**

Arthur A. Roth, M. D., Cleveland.

S-95 — **Anterior Cervical Fusion and the Treatment of Cervical Disk Conditions**

Donald F. Dohn, M. D., Cleveland Clinic, Cleveland.

S-96 — **Portal Hypertension—The Selection of Patients for Portal-Systemic Shunt**

R. E. Hermann, M. D., A. E. Rodriguez, M. D., B. H. Sullivan, Jr., M. D., C. H. Brown, M. D., and L. J. McCormack, M. D., Cleveland Clinic Foundation, Cleveland.

S-97 — **Simplified Cleft Lip Repair**

Robert C. Kratz, M. D., William B. Hofmann, M. D., Elvis R. Thompson, M. D., Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical School, Cincinnati.

S-98 — **A Program for Sedation and Analgesia in Obstetrics**

John C. Ullery, M. D., Douglas O. Clark, M. D., and James R. Bair, M. D., Ohio State University College of Medicine, Columbus.

S-99 — **Motorbike Safety**

R. C. Waltz, M. D., Karl Alfred, M. D., Vernon Hacker, M. D., J. D. Osmond, M. D., George Phalen, M. D., Committee on Trauma, Cleveland Academy of Medicine.

S-100—**Control of Hemorrhage by G-Suit**

John Storer, M. D., James Gardner, M. D., Huron Road Hospital, Cleveland.

S-101—**Office Evaluation of a Geriatric Patient**

Emmett W. Arnold, M. D., Director of Health, Aileen L. MacKenzie, M. D., Frances Williamson, Richard W. Orzechowski, Dennis Webb, Ohio Department of Health in cooperation with the U.S.P.H.S. Gerentology Branch, Columbus.

S-102—Carotid—Cavernous Fistula: Search for Effective Therapy

Wallace B. Hamby, M. D., Cleveland Clinic, Cleveland.

S-103—Advances in Diagnosis and Treatment of the Lymphomas

J. H. Berman, M. D., C. S. Higley, M. D., W. C. Stoner, M. D., Department of Hematology, St. Luke's Hospital, Cleveland.

S-104—Maternal Deaths from Anesthesia

Committee on Maternal Health, Ohio State Medical Association.

S-105—Traumatic Injury of the Thorax—The Flail Chest

Jorge Medina, M. D., Cleveland.

S-106—Auditory Findings in Lesions of the Pontine Portion of the Brain Stem

Willard Parker, M. D., Robert L. Decker, M. D., and Nelson G. Richards, M. D., Cleveland Clinic Foundation, Cleveland.

S-107—A New Spinal Technic

John S. Collis, M. D., Cleveland Clinic, Cleveland.

S-108—Stereoscopic Microangiography: Observations on the Microcirculation in Bone Repair

F. W. Rhinelander, M. D., R. S. Phillips, M. D., and W. M. Steel, M. D., Western Reserve University School of Medicine and Cleveland Metropolitan General Hospital, Cleveland.

S-109—Congestive Heart Failure in Local Water Supplies

Division of Chronic Diseases, Ohio Department of Health, Columbus.

S-110—Let's Control Rubella in Ohio

Gilbert M. Schiff, M. D., College of Medicine, University of Cincinnati.

HEALTH EDUCATION EXHIBITS

(Exhibit Hall Area)

H-111—FDA's Adverse Reaction Reporting Program

Food and Drug Administration, Bureau of Medicine, Washington, D. C.

H-112—Vocational Rehabilitation in Ohio

Bureau of Vocational Rehabilitation (State Board of Education), Columbus.

H-113—The Regulation of Dietary Fat

Mary Jane Kibler, American Medical Association, Chicago, Illinois.

H-114—The American Association of Blood Banks

E. A. Dreskin, M. D., President; Lois J. James, Central Office Manager, American Association of Blood Banks, Chicago, Illinois.

H-115—Activities of the Ohio Cancer Coordinating Committee, Inc.

Arthur G. James, M. D., President, Ohio Cancer Coordinating Committee, Inc., Columbus.

H-116—Packaged Disaster Hospital Familiarization Unit

Ohio Department of Health, Health Mobilization Unit and the OSMA Committee on Disaster Medical Care.

H-117—Ohio Medical History

Howard Dittrick Museum of Historical Medicine, Cleveland.

H-118—United Ostomy Association, Inc.

United Ostomy Association, Inc., Los Angeles, California.

H-119—Occupational Health Literature

Henry F. Howe, M. D., and Mr. Lee N. Hames, American Medical Association, Chicago, Illinois.

H-120—Checkups ARE Worthwhile

American Cancer Society, Ohio Division, Inc., Cleveland.

H-121—Coordinated Home Care

The Coordinated Home Care Program of Dayton and Montgomery County, Dayton, Ohio.

H-122—County Auxiliary Projects

Woman's Auxiliary to the Ohio State Medical Association.

Good Samaritan of Cincinnati Seminar on Premature Care

On April 21 the Pediatric Department of Good Samaritan Hospital, Cincinnati, will sponsor its Fourth Annual Seminar on Premature Care. This symposium will be held in the South 200 Conference Room of the Hospital from 1:00 P. M. to 6:00 P. M.

Dr. Ernst G. Rolfes, Chairman, has arranged an informative program that will be of great educational benefit to medical staff members. The speakers and their topics are:

Dr. Mary Ellen Engle, Associate Professor Pediatrics, Cornell University Medical College, speaking on "Diagnosis of Heart Disease in the Newborn Period."

Dr. William B. Richardson, Department of Surgery, Good Samaritan Hospital, speaking on "Recent Advances in Neonatal Surgical Care."

Dr. Alvin Zipursky, Assistant Professor - Pediatrics (Hematology), University of Manitoba, speaking on "Pathogenesis and Prevention of Rh Sensitization During Pregnancy."

There is no registration fee but advance notice should be given so that necessary arrangements can be made.

TECHNICAL EXHIBITORS

GRAND BALLROOM, MEZZANINE FLOOR, SHERATON-CLEVELAND HOTEL

Open from 10:00 A. M. to 5:30 P. M., Wednesday, May 25; from 9:00 A. M. to 5:30 P. M. on Thursday, May 26; and from 9:00 A. M. to 3:00 P. M. on Friday, May 27. (DST)

Exhibitor	Address	Booth No.
Allergy Laboratories of Ohio, Inc.,	Columbus, Ohio	30
Aloe Medical, Div. of Brunswick,	St. Louis, Mo.	32
The Americana Corporation,	Beverly Hills, California	49
Arnar-Stone Laboratories, Inc.,	Mt. Prospect, Ill.	57
Astra Pharmaceutical Products, Inc.,	Worcester, Mass.	29
Audio-Digest Foundation, Pacific Medical Equipment Co.,	N. Hollywood, Calif.	38
Ayerst Laboratories,	Arlington, Va.	13, 20
Barnes-Hind Laboratories,	Sunnyvale, California	18
Beverage Management, Inc., 7 Up Bottling Co.,	Columbus, Ohio	10
Breon Laboratories Inc.,	New York, N. Y.	63
Brewer & Company, Inc.,	Worcester, Mass.	50
Burroughs Wellcome & Co. (U.S.A.) Inc.,	Tuckahoe, N. Y.	45
Cameron-Miller Surgical Instruments Co.,	Chicago, Illinois	35
S. H. Camp & Co.,	Jackson, Michigan	27
Ciba Pharmaceutical Company,	Summit, N. J.	72, 73
Cleveland District Dairy Council,	Cleveland, Ohio	79
The Coca-Cola Company,	Atlanta, Ga.	23
P. F. Collier, Inc.,	New York, N. Y.	75
Daniels-Head & Associates, Inc.,	Portsmouth, Ohio	47
Davies, Rose-Hoyt,	Needham, Mass.	31
Dome Chemicals Inc.,	New York, N. Y.	39
Encyclopaedia Britannica, Inc.,	Chicago, Illinois	81
Esta Medical Laboratories,	New York, N. Y.	43
Fellows-Testagar, Div. of Fellows Medical Manufacturing Co., Inc.,	Detroit, Michigan	61
Fringe Benefits, Inc.,	Cleveland, Ohio	53
Geigy Pharmaceuticals,	Yonkers, N. Y.	1
Gerber Products Company,	Fremont, Michigan	4
Greene & Ladd, Members New York Stock Exchange,	Columbus, Ohio	15
Hartzmark & Co., Inc.,	Cleveland, Ohio	9
Hewlett Packard Co., Sanborn Division,	Waltham, Mass.	34
Hoechst Pharmaceuticals, Inc.,	Cincinnati, Ohio	26
Huntington National Bank,	Columbus, Ohio	60
Key Pharmaceuticals, Inc.,	Miami, Florida	11
Lederle Laboratories, Div. American Cyanamid Co.,	Pearl River, N. Y.	3
Lemmon Pharmacal Company,	Sellersville, Pa.	12
Eli Lilly and Company,	Indianapolis, Ind.	51
J. B. Lippincott Company,	Philadelphia, Pa.	76
Loma Linda Foods,	Riverside, California	41
Mead Johnson Laboratories,	Evansville, Ind.	70
Medco Products Co., Inc.,	Tulsa, Oklahoma	14
The Medical Protective Company,	Fort Wayne, Ind.	33
Merck Sharp & Dohme,	West Point, Pa.	46
The Wm. S. Merrell Co.,	Cincinnati, Ohio	84
North American Pharmacal,	Dearborn, Michigan	7
Ohio Bell Telephone Co.,	Cleveland, Ohio	71
Ohio Medical Indemnity, Inc.,	Columbus, Ohio	6
Ohio Medical Political Action Committee,	Columbus, Ohio	42
Ohio State Society of Medical Assistants		16
Ortho Pharmaceutical Corp.,	Raritan, N. J.	77
Parke, Davis & Company,	Detroit, Michigan	66
Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc.,	New York, N. Y.	65
Philips Roxane Laboratories,	Columbus, Ohio	54
Physicians' Placement Service,	OSMA	80
Professional Building & Equipment Corp.,	Mansfield, Ohio	8
Roche Laboratories,	Nutley, N. J.	17
J. B. Roerig & Company,	New York, N. Y.	62
Ross Laboratories,	Columbus, Ohio	55
Sandoz Pharmaceuticals,	Hanover, N. J.	44
W. B. Saunders Company,	Philadelphia, Pa.	2
The Schuemann-Jones Co.,	Cleveland, O.	36, 37
G. D. Searle & Co.,	Chicago, Illinois	58
Siemens Medical of America, Inc.	Hinsdale, Illinois	21
Smith Kline & French Laboratories,	Philadelphia, Pa.	56
Smith, Miller & Patch, Inc.,	New York, N. Y.	40
Spray Lin, Inc.,	Cleveland, Ohio	19
E. R. Squibb & Sons,	New York, N. Y.	25
Stiefel Laboratories, Inc.,	Oak Hill, N. Y.	69
Stryker Corporation,	Kalamazoo, Mich.	64
Swift & Company,	Chicago, Illinois	68
3M Company, Business Products Center,	Cleveland, Ohio	48
Turner and Shepard, Inc.,	Columbus, Ohio	83
S. J. Tutag and Company,	Detroit, Michigan	74
The Upjohn Company,	Kalamazoo, Michigan	28
U. S. Vitamin & Pharmaceutical Corporation,	New York, N. Y.	24
Wallace Laboratories, Div. of Carter-Wallace, Inc.,	Cranbury, N. J.	59
Winthrop Laboratories,	New York, N. Y.	22
Max Wocher & Son Co.,	Cincinnati, Ohio	67
X-ray Identification Corporation,	Dearborn, Michigan	5
Yale Medical Supply Company,	Royal Oak, Michigan	52

Things to do in ... CLEVELAND

Listed below are many varied activities, events and places that may be of interest to those attending the Annual Meeting. Included are activities during the period May 24 - May 31.

BASEBALL

CLEVELAND STADIUM
W. 3rd at Lakeside Avenue

May 27 — 7:30 P. M. Minnesota
May 28 — 2:15 P. M. Minnesota
May 29 — 1:00 P. M. Minnesota
Doubleheader

HORSE RACING

RUNNING RACES

Daily, except Sundays
Post Time — 2:15 P. M.
THISTLEDOWN, Warrensville Center Rd. at Emery Rd.

NIGHT HARNESS RACES

Post Time — 8:30 P. M.
NORTHFIELD PARK
Northfield, Ohio

BOAT TOURS

THE GOODTIME BOATS — Beginning May 9th daily River cruise at 10:00 A. M. Starting May 30th, narrated River tours depart daily from E. 9th St. pier at 11:00 A. M., 2:00 P. M. and 6:30 P. M. Lake and Harbor cruise daily at 4:30 P. M. Dance cruises every night, except Monday, at 9:00 and 10:30 P. M.

ERIE VIEW BOATS — Starting May 27 narrated River tours depart daily from E. 9th St. Pier on Showboat Paddlewheeler and "Route 66" T. V. Showboat Carol Diane at 11:15 A. M., 1:15, 2:15, 3:15 and 6:00 P. M. Starlight and cruise dances Friday and Saturday nights at 9:15 P. M. and Midnight on Showboat Paddlewheeler. Lake and harbor cruises daily. Charter service for dances on heated Paddlewheeler winter and summer. Telephone 771-0450 or 771-4414.

THEATRE

KARAMU THEATRE — 2355 East 89th St.

Tuesdays through Saturdays, 8:30 P. M.
Sundays, 7:30 P. M.
May 6 - June 25 "The House of Flowers" — Proscenium Theatre
May 20 - June 25 "The Death and Life of Sneaky Fitch" — Arena Theatre

LAKEWOOD LITTLE THEATRE
17823 Detroit Avenue

Wednesdays through Saturdays, 8:30 P. M.
May 4 - 28 "Never Too Late"

MUSEUMS

THE CLEVELAND MUSEUM OF ART
11150 East Boulevard

Tuesday, Thursday and Friday — 10:00 A. M. to 6:00 P. M.
Wednesday, 10:00 A. M. to 10:00 P. M.
Saturday, 9:00 A. M. to 5:00 P. M.
Sunday 1:00 to 6:00 P. M. — Closed Mondays

CLEVELAND MUSEUM OF NATURAL HISTORY
10600 East Boulevard

Weekdays, 9:00 A. M. to 5:00 P. M.
Sundays, 1:00 to 5:00 P. M. — Closed Mondays
Observatory open Wednesday evenings, 8:30 to 11:00 P. M.

THE HOWARD DITTRICK MUSEUM OF HISTORICAL MEDICINE
11000 Euclid Avenue

Monday through Saturday, 1:00 to 5:00 P. M.
Closed Sunday
Nearly 10,000 interesting objects relating to the history of medicine, dentistry and pharmacy from all periods of history, with special emphasis on Cleveland and the Western Reserve.

THE WESTERN RESERVE HISTORICAL SOCIETY
10825 East Boulevard

Weekdays, 10:00 A. M. to 5:00 P. M.
Sundays, 2:00 P. M. to 5:00 P. M. — Closed Mondays.
Permanent exhibits of Period Furniture, Costumes, China, Glass, Lighting Material, Ohio Made Pottery, Transportation and Communication.

AUTO AVIATION MUSEUM OF THE WESTERN RESERVE HISTORICAL SOCIETY
10825 East Boulevard

Tuesdays through Saturdays, 10:00 A. M. to 5:00 P. M.
Sundays, 2:00 to 5:00 P. M. Closed Mondays.
Exhibit of 130 ancient autos and assorted flying machines.

THE CLEVELAND HEALTH MUSEUM
8911 Euclid Avenue

Weekdays, 9:00 A. M. to 5:00 P. M.
Sundays, 1:00 P. M. to 5:00 P. M.
Home of "JUNO" — the Transparent Woman.

SHOPPING

America's sixth greatest concentration of domestic and foreign merchandise is to be found in the major department and specialty stores located between Public Square and East 14th Street on Euclid, Prospect and Huron Avenues. Store hours are as follows:

Monday	9:30 A. M. - 9:00 P. M.
Tuesday	9:30 A. M. - 5:45 P. M.
Wednesday	9:30 A. M. - 5:45 P. M.
Thursday	9:30 A. M. - 9:00 P. M.
Friday	9:30 A. M. - 5:45 P. M.
Saturday	9:30 A. M. - 5:45 P. M.

CHURCH SERVICES

Church services in the downtown area are listed here for Sunday, unless otherwise noted.

CATHOLIC — St. John's Cathedral, E. 9th and Superior Ave. Masses: 2:00, 5:15, 6:00, 7:00, 8:00, 9:00, 10:00, 11:00 a. m., 12:15 p. m.

CHRISTIAN SCIENCE — Fourth Church of Christ, Scientist, 10515 Chester Ave., 11:00 a. m. Wednesdays, 8:00 p. m.

EMANUEL EVANGELICAL UNITED BRETHREN CHURCH — W. 14th St. and Starkweather, 10:45 a. m.

EPISCOPAL — Trinity Cathedral, Euclid at E. 22nd St., 8:00 and 11:00 a. m.

JEWISH — The Temple, Ansel Rd., and E. 105th St., Fridays, 5:30 p. m., Saturdays, 11:00 a. m., Sundays, 10:30 a. m.

LUTHERAN — Trinity Evangelical Lutheran Church, 2049 W. 30th St., 10:30 a. m.

METHODIST — First Methodist Church, Euclid at E. 30th St., 10:45 a. m.

MORMON — Church of Jesus Christ of Latter Day Saints, 9509 Lake Ave., 10:30 a. m.

ORTHODOX — St. Theodosius Cathedral, 733 Starkweather St., 8:30 and 10:30 a. m.

PRESBYTERIAN — Old Stone Church on Public Square, 10:45 a. m.

POINTS OF INTEREST

AQUARIUM — Gordon Park at E. 72nd Street

Weekdays 10:00 A. M. to 5:00 P. M.
Sundays, 12:00 Noon to 6:00 P. M.
Closed Mondays

PLANETARIUM — 10600 East Boulevard

Public programs Saturdays and Sundays at 2:00, 3:00 and 4:00 P. M. Closed Mondays.

BUILDERS EXCHANGE HOME EXHIBITS
1737 Euclid Ave.

Nothing sold. Free exhibit presents best features and materials for home building and remodeling. Weekdays 10:00 A. M. to 5:00 P. M. Saturdays, 10:00 A. M. to 12:00 Noon.

NELA PARK — East Cleveland, Noble Rd.

General Electric Lighting Institute. Full-scale demonstrations of advanced lighting for residential, commercial, and industrial areas. Group programs by appointment. Tours for business visitors at 10 a. m. and 3 p. m., Monday through Friday. Open to the public Tuesdays, 7:30 p. m. to 10:00 p. m.

ZOO — West 25th and Brookside Park

Open daily, 10:00 A. M. to 5:00 P. M.
Sundays and Holidays, 10:00 A. M. to 7:00 P. M.

CLEVELAND STADIUM

Seating capacity 80,000. Home of the Cleveland Indians and Cleveland Browns.

AIRPORT — Cleveland Hopkins International

Among the largest airports in the world. Seven miles southwest of Cleveland. Home of NASA flight propulsion research.

TERMINAL TOWER

Eighth tallest building in the world. Observation floor open daily 9:00 a. M. to 5:00 P. M. Admission charge.

CLEVELAND PUBLIC LIBRARY
325 Superior Avenue

A world-famous research library, the second largest public library in the United States.

Drug Information Association, Allied Groups to Meet

New techniques for processing the enormous amount of information about drugs that pours from drug firms, universities, government agencies and medical organizations will be aired in Chicago on June 25-26, at the 1966 meeting of the Drug Information Association. "Advances in Drug Information Processing" is the theme of the meeting.

The Drug Information Association is a recently-formed organization which held its first national meeting in October, 1965. Its membership consists of representatives of the American Medical Association and other medical or para-medical groups, the Food and Drug Administration and other government agencies, pharmaceutical firms, and universities. Its purpose is "to further modern technology of communcation in medical, pharmaceutical and allied fields."

Separate Events of Special Groups During Annual Meeting Week

IN addition to features in the Annual Meeting Program, cosponsored in many instances, a number of specialty societies and other special groups are holding independent meetings, luncheons and dinners for their respective members during the week of the OSMA Annual Meeting. Readers should consult the program for parts these groups are playing in the scientific program.

Following is information on events of special interest announced to *The Journal* before this issue went to press.

Wednesday, May 25

Ohio Medical Political Action Committee: 11:30 A. M., luncheon in the Gold Room, Mezzanine Floor to be followed by Hoyt D. Gardner, M. D., of Louisville, Kentucky, Member of AMPAC Board of Directors. Dr. Gardner's talk will be on "Success Can Be Ours." The luncheon is $5.00 per person. 1:30 P. M., OMPAC Board Meeting, Parlor 34, Parlor Floor, Sheraton Cleveland Hotel.

Ohio Psychiatric Association and the Cleveland Society of Neurology and Psychiatry: 6:00 P. M. dinner, Lewis Room, Lobby Floor, Sheraton Cleveland Hotel. First Ewing Crawfis Memorial Address: "Osler's 'Way of Life' amended for the Space of Age." Speaker: W. Donald Ross, M. D., President, O. P. A., Professor of Psychiatry, University of Cincinnati College of Medicine.

Cleveland Ophthalmological Club: 6:30 P. M., cocktails and dinner at Wade Park Manor. Guest speaker: John G. Bellows, M. D., Chicago. Speaking on "Life History of the Lens." Tickets at $10 each may be secured at the door.

OSMA Section for Hospital Directors of Medical Education: 4:00 P. M., organizational meeting, Mohawk Room, First Floor followed by OSMA sponsored reception for those Hospital Directors in attendance in the Navajo Room, First Floor, Sheraton-Cleveland Hotel.

Ohio Society of Internal Medicine: 6:30 P. M., cocktails followed by dinner at 7:30 P. M., Board of Directors Meeting, Wigwam Room, First Floor.

Thursday, May 26

Ohio State Surgical Association: 10:30 A. M., registration of members in Parlor 34, followed by Past President's Luncheon in Parlor 32 at 12:00 NOON in the Sheraton-Cleveland Hotel.

Ohio Psychiatric Association Luncheon and Business Meeting: 11:45 A. M., Empire Room, Parlor Floor, Sheraton-Cleveland Hotel.

Ohio Academy of Medical History: 6:00 P. M., cocktails and dinner at the Howard Dittrick Museum of Historical Medicine, Cleveland Medical Library, 11000 Euclid Avenue. After dinner speaker: Dr. John J. Beeston, Director of the Cleveland Health Museum. Title of speech: "1066 and All That." 8:00 P. M., inspection of rare medical books in the Cleveland Medical Library.

Ohio Society of Internal Medicine: 6:30 P. M., reception followed by a dinner at 7:30 P. M. in the Grand Ballroom — Terrace, Parlor Floor, Sheraton-Cleveland Hotel.

Ohio State Surgical Association: 6:30 P. M., cocktail hour and banquet, Cleveland Room, Lobby Floor. Open to other than members by preregistration. Speaker: Thomas L. Dwyer, M. D., Mexico, Missouri, President of the American Association of Physicians and Surgeons. 10:30 P. M., Board of Directors' Hospitality Party, Navajo Room, First Floor, Sheraton-Cleveland Hotel.

Cleveland Society of Anesthesiologists: 6:30 P. M., dinner, Gold and Whitehall Rooms, Mezzanine Floor.

Jefferson Medical College Alumni Reunion: 6:30 P. M., fellowship hour followed by dinner at 7:30 P. M., in the Terminal Room, Parlor Floor, Sheraton-Cleveland Hotel.

Ohio Health Commissioners: 6:00 P. M., reception followed by dinner at 7:00 P. M. in the Erie and Empire Rooms, Parlor Floor, Sheraton-Cleveland Hotel.

Friday, May 27

Ohio Chapter, American Academy of Pediatrics: 9:30 A. M., Parlor 24, Parlor Floor, Executive Committee meeting, Sheraton-Cleveland Hotel.

Ohio State Surgical Association: 12:00 NOON, Navajo Room, First Floor — New President's luncheon.

Ohio Orthopaedic Society: 6:30 P. M., cocktails and banquet in the Grand Ballroom — Terrace, Parlor Floor, Sheraton-Cleveland Hotel.

Advance Resolutions, Nominations To Be Published in May Issue

Resolutions filed at the OSMA Headquarters Office in advance for presentation at the OSMA 1966 Annual Meeting will be published in the May issue of *The Journal,* and copies also will be mailed to members of the House of Delegates.

The deadline for filing was March 25. A resolution not filed with the Executive Secretary 60 days before the meeting may be presented only if the deadline requirement is waived by a two-thirds vote of the House.

Only an authorized member of the House of Delegates may present a resolution, and each resolution must be presented at the first session of the House even though it was submitted in advance. Copies in triplicate are to be furnished at time of presentation.

Under a new provision of the OSMA By-laws, nominations for the office of President-Elect are to be made and announced to the Headquarters Office 60 days in advance of the election. Information on persons nominated before the deadline will be published in the May issue also. These provisions may be waived only by a two-thirds majority of the House of Delegates.

Ohio Chapter, American Academy of Pediatrics, Northern Ohio Pediatric Society and the OSMA Section on Pediatrics: 8:00 P. M., banquet and dance, Cleveland Room, Lobby Floor, Sheraton-Cleveland Hotel.

Ohio Society of Pathologists: 8:00 P. M., banquet in the Empire and Erie Rooms, Parlor Floor, Sheraton-Cleveland Hotel.

Ohio Ear, Nose and Throat Society, and Section on Ear, Nose and Throat: 6:45 P. M., cocktails, Terminal Room, Parlor Floor followed by dinner at 7:30 P. M. Speaker: Joseph H. Ogura, M. D., St. Louis, Missouri, "Amusing Experiences in Laryngology over the Years."

Ohio Society of Physical Medicine and Rehabilitation: 8:00 P. M., dinner in the Navajo Room, First Floor, Sheraton-Cleveland Hotel.

Saturday, May 28

Ohio Association of Blood Banks: 12:00 NOON, Gold Room, Mezzanine Floor, Sheraton-Cleveland Hotel, organizational meeting and luncheon.

Cleveland Health Museum Offers "Operation Bus Stop"

The Women's Committee of the Cleveland Health Museum offers the doctors' wives a cultural and delightful form of entertainment during the coming Annual Meeting in Cleveland.

The Committee's "Operation Bus Stop," a four-hour luncheon tour of Cleveland highlights, will be comprised of the following features:

Hostesses from the Women's Committee will meet the women at their hotel at 9:45 A.M. and accompany them on a descriptive chartered bus trip of the cultural center of Cleveland. This will include views of the Lake Erie shoreline and the Cleveland Stadium, home of the Browns and Indians. The tour proceeds to University Circle which is composed of more than thirty cultural, educational, medical and service institutions in a setting of natural and architectural beauty. The Cleveland Museum of Art and the home of the world-famous Cleveland Orchestra are located in this area, and the group will visit the recently opened New Garden Center of Greater Cleveland.

A stop is in order at the Cleveland Health Museum, for an hour's guided tour of this remarkable and unique institution, the first of its kind in the country. In addition to exciting displays showing how the human body functions, new exhibits from the New York World's Fair, including an electronic representation of the human brain, may be seen.

Luncheon follows at a private town club of choice. Over the teacups hostesses will suggest shopping tips. The women will be promptly returned to their hotels at 2:00 P.M.

Proceeds from "Operation Bus Stop" will further the progress of the Cleveland Health Museum, that all may enjoy good health.

Time: 10:00 A. M. to 2:00 P. M. $7.50 per person (minimum 40 people).

Tour date reservations must be made 3 weeks in advance.

For further information contact Mrs. Adalyn B. Ross, Special Tours Representative, Cleveland Health Museum, 8911 Euclid Avenue, Cleveland, Ohio 44106.

University of Virginia Alumni Cleveland Reception

A cocktail reception will be held on Thursday evening, May 26, at about 5:30 P.M. in the Navajo Room of the Sheraton-Cleveland Hotel, for all medical alumni, interns, and residents of the University of Virginia.

Dr. Chester R. Nuckolls, of Cleveland, chairman for Ohio, will serve as host for the reception, and Dr. A. J. Gabriele, of Dayton, as cohost. The reception is scheduled in connection with the Annual Meeting of the Ohio State Medical Association.

Proceedings of The Council ...

Report of Matters Discussed and Actions Taken at Meeting of The Council in Columbus on February 20

A REGULAR MEETING of The Council of the Ohio State Medical Association was held February 20, 1966, at the headquarters office, Columbus. All members of The Council were present except Dr. Philip B. Hardymon, Columbus, Treasurer, and Dr. Robert C. Beardsley, Zanesville, Councilor of the Eighth District. Others attending the meeting were: Drs. Richard L. Meiling, Columbus, and John H. Budd, Cleveland, delegates to the AMA; Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff.

AMA Pathologist-Hospital Agreement Withdrawn

President Crawford read a letter dated February 9 from Dr. F. J. L. Blasingame, Executive Vice President of the AMA, acknowledging Dr. Crawford's letter of January 18, in which he raised a number of questions about a sample form of agreement between a pathologist and a hospital. This agreement had been prepared by the AMA Law Department after consultation with the staff of the College of American Pathologists and with the assistance of the AMA Department of Hospitals and Related Facilities. Dr. Blasingame stated that, in view of the objections from the Ohio State Medical Association, the form was being withdrawn from further distribution.

Plaques for Physicians Serving In Vietnam

It was announced that the American Medical Association will issue plaques to physician volunteers who have served in the project Vietnam program. It was The Council's opinion that these should be presented at the OSMA Annual Meeting.

Minutes Approved

Minutes of the meeting of The Council held December 11-12, 1965, **were approved** by official action. Minutes of the meeting of the Committee on Auditing and Appropriations held December 30, 1965, **were ratified.**

Reports of Councilors

The Councilors reported on activities in their respective districts.

Radiology and Laboratory Services

In connection with the report of the Tenth District, Dr. Fulton submitted a letter from Dr. William B. Schwartz, Director, Department of Radiology, Riverside Methodist Hospital, Columbus.

Dr. Schwartz reported that the hospital administrator and the President of Blue Cross of Central Ohio had been developing a plan that would provide insurance coverage for preadmission outpatient diagnostic radiology and laboratory services to patients who were scheduled for subsequent admission to Riverside Hospital. This insurance coverage would be offered by the Blue Cross Plan. Dr. Schwartz expressed very strong objection on the part of his group of radiologists to this plan.

Dr. Fulton stated that a committee of the Columbus Academy of Medicine was investigating this matter.

The Council instructed the Executive Secretary to communicate with the Columbus Academy of Medicine and ask for a report of the Academy's deliberations and requested that The Council be kept informed of developments.

1966 Annual Meeting

A progress report on the 1966 Annual Meeting in Cleveland, May 24 - May 28, was presented by Mr. Traphagan.

The Council voted to decline with thanks an offer from the Mead Johnson Company to present an award in connection with the scientific exhibit.

Six resolutions filed with the Executive Secretary for the 1966 Annual Meeting in May were referred to The Council for information.

Ohio Medical Indemnity

A resolution by the Ohio Medical Indemnity Board of Directors, unanimously adopted at a regular meeting of the Board on January 19, 1966, was received for the information of The Council. Such resolution requested the executive office of the National Association of Blue Shield Plans to refrain from issuing publicity and statements "which imply that the prevailing fees concept is the official policy of the National Association of Blue Shield Plans" and which confuse the profession and the public concerning this and the "usual and customary fee" method of compensation approved and supported by the House of Delegates of the American Medical Association.

The resolution also pointed out that there are important basic differences between the so called prevailing fees technique and the usual and customary fee concept which has been approved by the Ohio State Medical Association and which is the keystone of the comprehensive contract of Ohio Medical Indemnity, Inc. National Blue Shield publicity has implied that the plans are the same.

The committee to select nominees for the OMI Board of Directors, to be voted on in April, was announced by the President, as follows: Dr. Robert E. Tschantz, Canton, chairman; Dr. Robert N. Smith, Toledo and Dr. Robert E. Howard, Cincinnati.

An advertisement by Hospital Service Association of Canton, cosigned by Blue Shield and Blue Cross, was brought to the attention of The Council by Dr. Tschantz.

1966 County Society Officers Conference

Mr. Edgar announced plans for the County Medical Society Officers Conference to be held on Sunday, February 27, at the Pick Fort-Hayes Hotel.

Meeting of County Society Executive Secretaries

The Council voted to repeat its cosponsorship of a conference of Ohio county medical society executives at the AMA Headquarters in Chicago, August 23, the day preceding the annual seminar of the Medical Society Executives Association and the AMA Public Relations Institute. The Council authorized the appropriation of sufficient funds to reimburse each executive attending to the extent of $75.00.

Resolution To Be Resubmitted to AMA in June

Dr. Budd and Dr. Meiling discussed the coming meeting of the AMA House of Delegates, June 23, 1966, in Chicago. The Council instructed the delegates and the staff to draft a resolution demanding that AMA Councils to which resolutions of the AMA House of Delegates are referred for study or implementation be obligated to invite representatives of the originating delegation to hearings which are held on such resolutions. It was noted that the Ohio delegates were not invited to participate in Council on Medical Education discussions of Resolution No. 7 on osteopathy (AMA Annual Meeting, 1965) nor to hearings on Resolution No. 60 regarding definitive care of American casualties of the war in Vietnam in the continental United States (AMA Clinical Meeting, 1965).

The Council voted to instruct the Ohio AMA delegates to resubmit Resolution No. 7 regarding the eligibility of osteopathic physicians for internships and residency programs, to the Annual Meeting of the AMA in 1966. This resolution originated from Resolution No. 17, Ohio House of Delegates, May, 1965.

The Council reviewed correspondence between Dr. Meiling and Dr. Milford O. Rouse, Speaker of the AMA House of Delegates, and voted to instruct the delegates and staff to draft a resolution for consideration at the next meeting of The Council for possible presentation to the AMA House of Delegates, embodying the concept of four business meetings of the AMA House each year in Chicago with ceremonial meetings and elections being left to the annual and clinical AMA scientific sessions.

Dr. Budd reported on the initial meeting of the Committee on Future Development and Planning for the AMA.

Medicare

Mr. Edgar reported that the Nationwide Mutual Insurance Company and Medical Mutual of Cleveland, Inc., had been chosen as intermediaries in connection with the administration of Part B of Medicare in Ohio. Ohio Medical Indemnity, Inc., Ohio's Blue Shield Plan, applied for consideration as an intermediary but was not one of those chosen.

Dr. Light, who had been appointed by President Crawford as an OSMA representative on the Medical Care Advisory Committee to the Ohio Director of Public Welfare on medical assistance problems, reported on a meeting of this committee held on February 18. Dr. Light said that one of the problems being faced by the Welfare Department is that, by virtue of the Medicare Law, many of the department's costs are cared for under Part A of the Act and that it is indicated that $8,000,000 of the present budget might become available. The concept of using such funds to buy Part B insurance is being considered by the department. The Advisory Committee is so recommending.

Mr. Edgar reported that in discussions of Title 19, wherein all five major programs will be combined in Ohio, the idea of paying the individual physician's usual and customary fee is being presented by the OSMA to the Welfare Department officials and that the Ohio Citizens Council for Health and Welfare, a voluntary organization in the welfare field, is investigating this concept for possible recommendation to the Welfare Department.

S. B. 2568, the Hart Bill

The Council discussed Senate Bill 2568, the Hart Bill, which would prohibit the dispensing of pharmaceuticals, "devices" and "other products" by physicians at a profit. The definition of the term "profit" in the bill is "**any markup above the actual cost of the product**" to the physician. Also covered is any discount, refund, rebate, commission, rental for space leased from a physician based on a percentage of income from drugs or "devices" sold by the tenant. On **motion** duly made, seconded and **carried,** The Council voted **to oppose** Senate Bill 2568.

Drug Abuse Control Amendments of 1965

Mr. Page distributed communications which had been prepared and issued by the Columbus office to keep physicians informed about the Drug Abuse Control Amendments of 1965, P. L. 89-74.

Dirksen Amendment, S. J. R. 103

The Council discussed S. J. R. 103, known as the Dirksen Amendment, which is being considered by the 1966 session of the Congress and which would permit geographical factors to be taken into consideration in determining the districts from which members of one of the houses of two-house state legislatures are elected. By official action, The Council voted **to support** S. J. R. 103 and to send out informational materials on the proposal to the membership.

Federal Unemployment Compensation Bill

House Resolution 8282, the Federal Unemployment Compensation Bill, was then discussed. It was pointed out that this bill would force Federal stand-

ards on state unemployment insurance at huge increases in cost; that small businessmen and professional people, who now employ one or two and who are not now subject to the tax, would be required to pay both Federal and State Unemployment Taxes. It was also stated that the enactment of the bill would be the beginning of the end of merit rating in unemployment compensation so that small businessmen and professional men whose employees are not generally laid off by slack periods would be taxed at the same rates as industry with poor employment experience. The Council **voted** to **actively oppose** H. R. 8282.

Ohio Association of Blood Banks

A request for the endorsement of the organization of Ohio Association of Blood Banks **was referred** to the Committee on Laboratory medicine.

Physician Ownership of Pharmacies and Physician Dispensing

Regarding a request for advice on a resolution from the National Council of State Pharmaceutical Association Executives with regard to the AMA policy on physician ownership of pharmacies and physician dispensing, The Council **expressed the opinion** that the current AMA position on this matter is sound.

Medical Doctors Practicing in Osteopathic Hospitals

In answer to a request for an opinion on the ethics of medical doctors practicing in osteopathic hospitals, The Council reaffirmed that it is the responsibility of each county medical society in Ohio to determine whether it is, or is not, ethical for members of that society to voluntarily associate professionally with doctors of osteopathy, and that the statement adopted December 16-17, 1961, as the official policy of the Association still applies.

The four-point criteria recommended for use in determining the professional, ethical and scientific standing of a doctor of osteopathy is as follows:

"(1) The doctor of osteopathy must have qualified to practice osteopathic medicine and surgery under the Ohio Medical Practice Act as amended in 1943 which confers on him unrestricted rights and legal recognition in Ohio as a physician.

"(2) He must practice a method of healing founded on the principles of scientific medicine.

"(3) He must in good faith endeavor to conform to ethical principles equivalent to the Principles of Medical Ethics of the AMA.

"(4) His professional and scientific competence must be such that he can give his patients scientific medical care and make contributions to programs to maintain and improve the health of the community.

"In the opinion of The Council of the Ohio State Medical Association voluntary professional association between a doctor of medicine and a doctor of osteopathy who meets all the foregoing basic standards would not be deemed unethical."

Woman's Auxiliary

The Council **endorsed** the proposed program of the Woman's Auxiliary to conduct precinct action training courses and a doctor-wife voter registration campaign.

Travel Plan Request Approved

A request from the Cleveland Academy of Medicine for permission to include OSMA members in clinical or recreational trips arranged by the Travel Committee of the Cleveland Academy of Medicine **was approved.**

World Medical Association

The Executive Secretary **was instructed** to advise the U. S. Committee of the World Medical Association that funds would not be available for a contribution to that committee in 1966.

OSMA Group Life Insurance Plan

A report from Turner and Shepard on the OSMA Group Life Insurance Plan for the period March 1 to September 1, 1965, **was accepted** for information.

Mahoning County Amendments

Amendments to the Constitution and Bylaws of the Mahoning County Medical Society **were approved**, subject to the rewording of the language as suggested by the OSMA legal counsel.

OSMA Sponsored Major Medical Insurance

A request from Daniels-Head, Inc., for permission to waive underwriting for new OSMA members under age 40 years in connection with the OSMA sponsored major medical insurance **was granted.**

Funds for Student AMA

A request from the OSU Chapter, Student AMA, for funds to assist with the entertaining of student AMA members at the regional meeting of the organization in Columbus, April 2, was considered. The Council appropriated $275.00 to sponsor the dinner meeting of the registrants.

Workmen's Compensation

The Council endorsed the recommendation of the Committee on Workmen's Compensation that officers and staff of the Ohio State Medical Association meet with the officials of the Ohio Manufacturers' Association to explain to them the usual and customary fee concept as applied to Ohio Workmen's Compensation.

Doctor Draft Situation

Mr. Edgar told of developments in the doctor draft situation and indicated that this activity of the Ohio State Medical Association has again grown to the extent that much of the chairman's office time is taken up with telephone calls, delegations and correspondence with regard to military advisory activities.

Date Set for Next Meeting

The date for the next meeting of The Council was established as March 20, 1966.

Attest: HART F. PAGE,
Executive Secretary

Comments on Current Economic, Social And Professional Problems

MEDICO HELPS PEOPLE TO HELP THEMSELVES; MERITS SUPPORT

Many people associated with the medical field are unfamiliar with the work being done overseas by doctors, nurses and technicians who have unselfishly volunteered their time (often at their own expense) to work for MEDICO, the Medical International Cooperation Organization, founded in 1958 by Dr. Peter D. Comanduras and the late Dr. Tom Dooley.

This humanitarian organization became a service of CARE, Inc., in 1962 and since then has expanded its operations to many more Latin American, African, and Asian countries and, in a typical year, has helped half a million diseased and maimed persons on the road to better health.

MEDICO's advisory board includes many outstanding leaders of the American medical profession in both the United States and Canada, and it has been endorsed by 22 important medical, surgical, and allied specialty organizations, such as the American College of Surgeons and the American College of Physicians. Dr. Charles Hauser, of Hamilton, Ohio, has been appointed Assistant Executive Director of CARE in charge of MEDICO service.

There is a great need for personnel to man the overseas medical staffs and for contributions to continue their work. Physicians can help spread information about the work MEDICO is doing to friends and associates, perhaps by suggesting they include a MEDICO program in their county society programs.

The Columbus CARE office will supply speakers, films (13½ minutes in color), pamphlets and slides.

Interested persons may contact MEDICO by phoning Columbus 224-3858, or writing to MEDICO at 8 East Chestnut Street, Columbus, Ohio 43215.

MEDICO is devoting its efforts to helping people help themselves. In our opinion, it merits support.

CONTINUING EDUCATION, A MARK OF THE PROFESSION

Physicians are attending "refresher courses" and postgraduate education programs at ever increasing rates, according to the recent report of the AMA Council on Medical Education.

The number of refresher courses has increased by more than 50 per cent in the past five years. More than 71,000 physicians were registered in only half of the total number of courses offered last year, compared to about 18,000 in the 1954-1955 season.

The constant pace to study, to know, to keep up with the changing pace in clinical experience, in research, in development of drugs and equipment, is only one facet of professional life. It is a facet that will and does color the public "doctor image."

In this issue of *The Journal* are details on a number of Fall postgraduate programs being offered in Ohio. The AMA listing in a recent issue of *JAMA* gives some 1,641 postgraduate courses throughout the country, many of them in Ohio.

There is no other field, whether profession, craft or art, in which the individual constantly strives to equip himself for better service. It should be comfort to the American people to know that good doctors never stop studying, and today's physicians are studying more than ever.

EMOTIONAL PROBLEMS RELATED TO HEALTH OF SCHOOL CHILDREN

Emotional problems comprise the largest single group of health problems in the schools, according to a resolution on "Guidance and Health" adopted by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

Observing further that such problems are frequently multiple in origin as well as in manifestation, the committee's resolution states that medical aspects of such problems must not be overlooked.

The resolution concludes with the recommendation, "That schools establish policies and protocol to insure that each member of the team — such as teachers, psychiatrists, guidance personnel, psychologists, social workers, and physicians — function according to his ability and qualification, and that medical consultation always be available and utilized in the approach to these problems . . . That personnel responsible for guidance have adequate preparation in the area of health."

These are points well taken by the joint committee and deal with matters that need serious consideration in liaison between local County Medical Societies and school authorities.

OMPAC Membership Hits 2,610...

About 26% of Members Have Affiliated; Crawford County and the Tenth District Lead in Percentage

MEMBERSHIP in the Ohio Medical Political Action Committee stood at 2,610 on March 15. Membership cards have been mailed to approximately 2,000 physicians. Cards are mailed periodically. An effort is made to keep a steady flow of cards in the mail.

As of March 15, almost 26 per cent of the membership of the Ohio State Medical Association (10,042) had affiliated with OMPAC.

The Tenth and Second Councilor Districts were running neck and neck for OMPAC membership honors on a percentage basis. On March 15, the Tenth District had 428 OMPAC members. Its OSMA membership is 1103, giving it an OMPAC percentage membership of 39.3 per cent. The Second District with 892 OSMA members has 349 OMPAC members or 39.1 per cent.

Crawford County with 39 Ohio State Medical Association members was way ahead of the field with 35 OMPAC members or 89.7 per cent of its members affiliated with OMPAC.

A number of Woman's Auxiliary members have joined OMPAC during the past month, dues having been paid directly to OMPAC at P. O. Box 5617, Columbus, Ohio 43221.

Key Elections in Ohio

Widespread interest in the Ohio Medical Political Action Committee is picking up. In all probability this has been stimulated by a realization that Ohio will be one of the major battle grounds in the Congressional elections on next November 8. Hot contests are being anticipated in five or six of the Ohio Congressional districts. The results in these districts could make a substantial change in the make-up of Ohio's Congressional delegation. Physicians are beginning to realize that and they are getting anxious to get into the fray with help for their favorite candidates.

Physicians in most counties may acquire membership in OMPAC by paying the $25.00 OMPAC annual dues to the secretary-treasurer of their County Medical Society. In counties where collections are not being carried on in this manner, physicians may affiliate by sending dues directly to OMPAC, Post Office Box 5617, Columbus, Ohio 43221.

OMPAC Membership By Counties

Following is a tabulation showing the OSMA membership on last December 31 in the various counties, arranged by districts; the Ohio Medical Political Action Committee membership as of March 15, 1966; and the percentage of OMPAC members per district:

	OSMA Membership	OMPAC Membership to date	% OMPAC Membership
First District			
Adams	14	1	
Brown	15	6	
Butler	174	71	
Clermont	28	4	
Clinton	22	5	
Hamilton	1243	409	
Highland	19	0	
Warren	16	0	
	1531	496	32.4
Second District			
Champaign	17	0	
Clark	128	54	
Darke	24	7	
Greene	49	19	
Miami	62	37	
Montgomery	579	217	
Preble	11	0	
Shelby	22	15	
	892	349	39.1
Third District			
Allen	124	70	
Auglaize	16	2	
Crawford	39	35	
Hancock	47	3	
Hardin	26	0	
Logan	18	0	
Marion	66	13	
Mercer	21	2	
Seneca	45	22	
Van Wert	20	0	
Wyandot	11	3	
	433	150	34.6
Fourth District			
Defiance	21	4	
Fulton	17	3	
Henry	15	7	
Lucas	613	13	
Ottawa	23	7	
Paulding	7	1	
Putnam	12	0	
Sandusky	46	13	
Williams	18	0	
Wood	42	2	
	815	50	06.1

(Continued on Next Page)

OMPAC Membership *(Contd.)*

	OSMA Membership	OMPAC Membership to date	% OMPAC Membership
Fifth District			
Ashtabula	59	17	
Cuyahoga	2315	384	
Geauga	24	10	
Lake	108	57	
	2506	468	18.6
Sixth District			
Columbiana	67	5	
Mahoning	336	85	
Portage	55	26	
Stark	354	172	
Summit	572	0	
Trumbull	134	52	
	1518	340	22.4
Seventh District			
Belmont	55	18	
Carroll	10	6	
Coshocton	25	1	
Harrison	7	6	
Jefferson	63	2	
Monroe	3	0	
Tuscarawas	51	26	
	214	59	27.5
Eighth District			
Athens	37	13	
Fairfield	53	34	
Guernsey	29	4	
Licking	69	1	
Morgan	3	0	
Muskingum	73	26	
Noble	2	1	
Perry	10	3	
Washington	30	0	
	306	82	26.7
Ninth District			
Gallia	33	3	
Hocking	9	1	
Jackson	16	0	
Lawrence	22	15	
Meigs	6	0	
Pike	11	0	
Scioto	68	33	
Vinton	1	0	
	166	52	31.3
Tenth District			
Delaware	27	7	
Fayette	16	12	
Franklin	928	357	
Knox	36	25	
Madison	14	2	
Morrow	8	2	
Pickaway	17	6	
Ross	39	21	
Union	18	2	
	1103	434	39.3
Eleventh District			
Ashland	25	6	
Erie	67	0	
Holmes	10	6	
Huron	28	13	
Lorain	193	58	
Medina	57	18	
Richland	119	1	
Wayne	60	28	
	559	130	23.2

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May 20, 21 and 22, 1966

This course will cover the field of allergy from a practical viewpoint. Demonstrations of proper skin testing techniques and methods of treatment will be included.

The registration fee ($35.00) will include a book which will cover the practical care of allergic disease. The entire course is geared to help the practicing physician better care for the allergic patient. The book will contain all the lectures in detail, as well as aspects which cannot be completely covered within a few days.

The lectures will be supplemented by Kodachrome studies and round table discussions with question and answer periods.

The program is approved for 15 hours credit in Category I by the American Academy of General Practice.

For further information write:
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Methodist Hospital Graduate Medical Center
Indianapolis, Indiana 46207

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Obituaries

Ad Astra

Helen Jackson Alexander, M. D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 55; died February 6; member of the Ohio State Medical Association. A physician in the Cincinnati area, Dr. Alexander practiced under her maiden name of Helen Jackson. Her specialty was in the field of anesthesia. Survivors include her husband, Clarence Alexander, a son, a daughter, her father and a brother.

William F. Ashe, Jr., M. D., Columbus; Western Reserve University School of Medicine, 1936; aged 56; died February 27; member of the Ohio State Medical Association, the American Medical Association, American Academy of Occupational Medicine, Industrial Medical Association, American College of Preventive Medicine, and the Aerospace Medical Association; Fellow of the American College of Physicians. A former practicing physician in Gallipolis, Dr. Ashe in recent years was chairman of the Department of Preventive Medicine at Ohio State University College of Medicine. He retired last year and was named emeritus professor of preventive medicine. Before joining the OSU faculty, Dr. Ashe served a tour in India as consultant in thermal and environmental health, and in 1964 was vice-president of the American College of Preventive Medicine. He served from 1953 to 1958 on the OSMA Committee on Scientific Work. Surviving are his widow, four daughters, a son, four brothers and a sister.

Olen Dighton Ball, M. D., New Lexington; Ohio State University College of Medicine, 1935; aged 60; died February 16; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; past president of the Perry County Medical Society; former delegate and alternate delegate to the OSMA House of Delegates. A practicing physician of long standing in New Lexington, Dr. Ball established the Ball Clinic there in 1935. He was active in local affairs; served in all offices of the local Medical Society and on numerous of its committees. He also was Perry County coroner; was a veteran of World War II, and belonged to the Methodist Church, and the Masonic, Elks and Eagles Lodges. Surviving are his widow, two daughters, three sons, his father and a sister.

Alletta Maribel Bare, M. D., Cincinnati; University of Cincinnati College of Medicine, 1960; aged 34; died February 8 as the result of accidental gas poisoning; member of the Ohio State Medical Association and the American Medical Association. After receiving her medical degree, Dr. Bare took advanced training at the University of Nebraska and at Cincinnati General Hospital. Her practice was in the field of internal medicine. Born in China, the daughter of medical missionaries, she is survived by her mother who now lives in Portsmouth.

Irwin Henry Boesel, M. D., Springfield; University of Michigan Homeopathic Medical School, 1909; aged 79; died February 24; member of the Ohio State Medical Association, and the American Medical Association. A general practitioner in the Springfield area for some 42 years, Dr. Boesel was a veteran of World War I, during which he served in the Army Medical Corps. Affiliations included memberships in several Masonic bodies and in the Church of God. His widow, a son, two sisters, and a brother survive.

George S. Buttemiller, Sr., M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 87; died February 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Buttemiller was retired after practicing for many years in the Cincinnati area where he specialized in obstetrics and gynecology. Survivors include his widow and a son, Dr. George S. Buttemiller, Jr.

Lawrence I. Clark, M. D., Toledo; St. Louis University School of Medicine, 1923; aged 68; died February 8; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A native of Toledo, Dr. Clark served most of his professional career there, specializing in pediatrics. Among special interests, he was director of pediatrics at Opportunity Home and the Convalescent Home for Crippled Children. He was a member of the Catholic Church and the Holy Name Society. Surviving are his widow, two sons and a daughter.

Paul Josef Collander, M. D., Ashtabula; medical degree from Helsingfors University, Helsinki, Finland, 1903; aged 91; died February 10; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Radiology. A native of Finland, Dr. Collander came to this country early in his career and began parctice in Ashtabula in 1910. For many years he was the Finnish vice-consul, and during World War I served in the Medical Corps. He was a member of the Elks Lodge, the Exchange Club, Chamber of Commerce, and the Congregational Church. A son and a daughter survive.

George Thomas Day, M. D., Cleveland; Stritch School of Medicine of Loyola University, 1934; aged

The Ohio State Surgical Association presents . . .

"MEDICARE: ANOTHER VIEWPOINT"

— by THOMAS L. DWYER, M.D.
Mexico, Missouri
President
Association of American
Physicians and Surgeons

THURSDAY, MAY 26th
CLEVELAND

Dr. Dwyer will speak at a banquet in the Cleveland Room of the Sheraton Cleveland Hotel which is open to non-members of OSSA by pre-registration. Dr. Dwyer's appearance is the Association's contribution to the combined medical meeting idea actively sought by OSMA. We regret that Dr. James Z. Appel, President of the American Medical Association, could not appear on the program with Dr. Dwyer, but we have announced to our membership that the earlier talk by Dr. Charles L. Hudson, President-Elect of the AMA, on "Medicare's Rules and Regulations and Their Effect on the Practice of Medicine," as well as the Friday speech by Dr. Edward R. Annis, Past President of AMA, on "Care of the Patient, 1966," should be considered a part of our Association's total program. From these three offerings on the Medicare program, it is hoped that our membership can obtain the information they need to arrive at an individual decision on the matter of Medicare participation or non-participation. The Association itself has not taken a stand. Please complete and mail the form below if you wish to attend the banquet at which Dr. Dwyer will speak.

ROBERT G. SMITH, M. D.
President

Please reserve_____tickets at $10.00 each for the Ohio State Surgical Association reception and banquet at which Dr. Thomas L. Dwyer, President of the Association of American Physicians and Surgeons, will speak.

_____Enclosed is my check for _____. I understand that there will be no additional charges during the reception hour preceding the banquet.

_____ I will pay upon arrival.

Thank you.

_____
name (please print or use stamp)

_____
address

_____ member _____ non-member

Mail to: Ohio State Surgical Association
526 E. Dunedin Rd.
Columbus, Ohio 43214

59; died February 20; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Day's practice in the Cleveland area extended over approximately 30 years. During World War II, he served in the Medical Corps of the Navy and attained the rank of lieutenant commander. A member of the Catholic Church and the Holy Name Society, he is survived by his widow, a son and four daughters.

J. Gordon Griffin, M. D., Akron; Western Reserve University School of Medicine, 1905; aged 86; died February 24; former member of the Ohio State Medical Association. Dr. Griffin moved to Akron in 1914 and practiced there until his retirement in 1957. He previously practiced in Lorain and on Kelley's Island. Among affiliations, he was a member of the Elks Lodge. A daughter survives.

William C. Gutermuth, M. D., Versailles; Hospital College of Medicine, Louisville, 1893; aged 93; died February 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Gutermuth's practice in the Versailles area extended from 1894 until his retirement in 1949. Among affiliations, he was a member of the Lutheran Church, a past master of the Masonic Lodge and belonged to other Masonic orders. Survivors include three sons, a daughter, a brother, and three sisters.

Harold K. Harris, M. D., Columbus; Ohio State University College of Medicine, 1925; aged 65; died February 11; member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in Columbus, Dr. Harris was one of the founders of Lincoln Memorial Hospital. Among affiliations, he held memberships in several Masonic bodies. Three stepdaughters and a step-son survive.

Lothar Z. Hoffer, M. D., Lorain; Medical Faculty of the University of Hamburg, 1923; aged 70; died February 11; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Germany and former practitioner in Hamburg, Dr. Hoffer came to this country in 1938 and began practice in Lorain in 1940. He was a member of the Temple, the Zionist Organization, and B'nai B'rith. Among survivors are his widow, a son, and a brother.

Ralph W. Holmes, M. D., Chillicothe; Ohio Medical University, Columbus, 1901; aged 89; died February 1; member of the Ohio State Medical Association, the American Medical Association, American Roentgen Ray Society, Radiological Society of North America; diplomate of the American Board of Radiology; past president of the Ross County Academy of Medicine. A practitioner of long standing in Chillicothe, Dr. Holmes pioneered in radiology. For many years he was radiologist for the Chillicothe Hospital and was also consultant to the VA Hospital and Federal Reformatory Hospital. In addition to numerous local activities, he was a member of the board of directors and past president of the Ohio Society for Crippled Children and Adults, and past president of the Ohio State Radiological Society; also a member of the Silicosis Board of the Ohio Industrial Commission. A veteran of World War I, he was a member of the Rotary Club, the Sunset Club, and the Elks Lodge. Surviving are his widow and two sons, one of whom is Dr. Nicholas H. Holmes, also of Chillicothe.

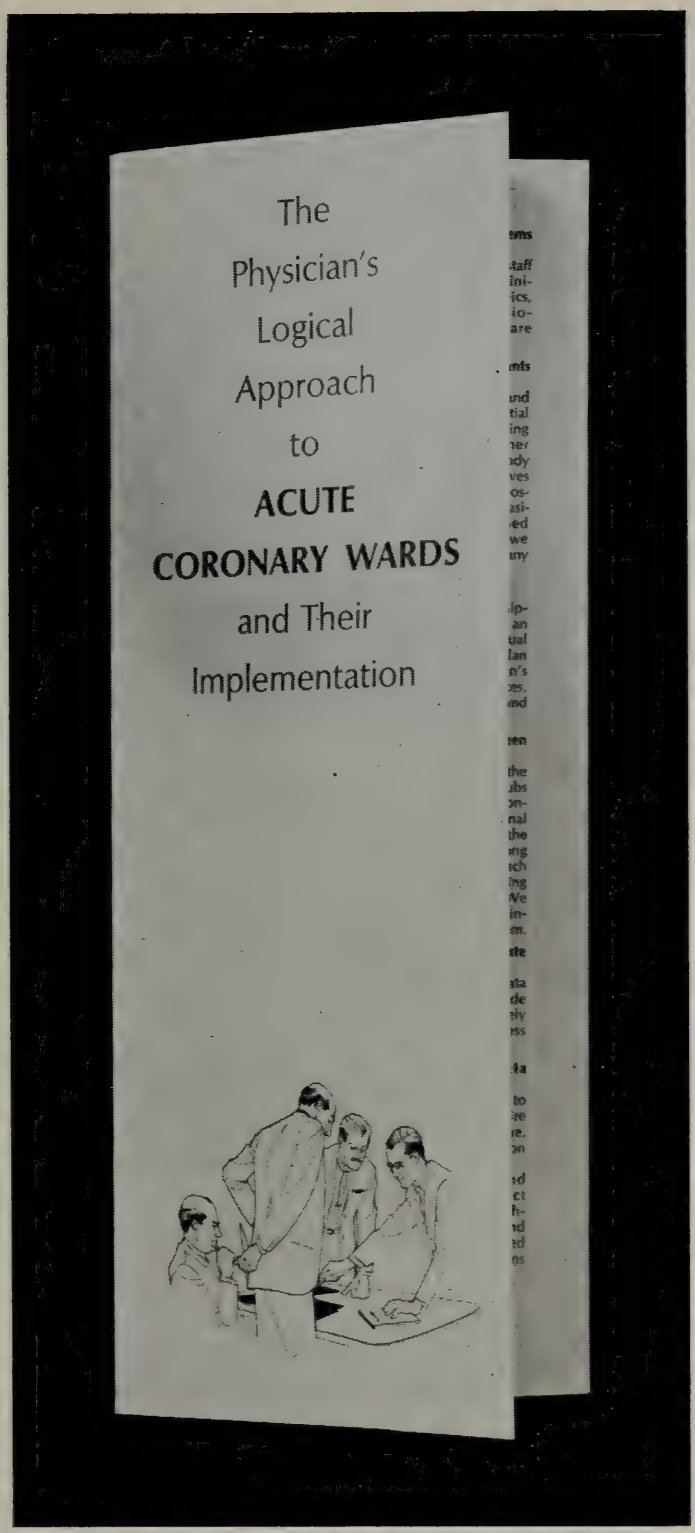
Edward J. Keefe, M. D., East Cleveland; Western Reserve University School of Medicine, 1930; aged 62; died February 26; member of the Ohio State Medical Association and the American Medical Association. After completing his internship at St. Vincent Charity Hospital, Dr. Keefe established his practice in East Cleveland 35 years ago. His field was general practice and general surgery. Among affiliations, he was a member of the Catholic Church and the Holy Name Society. Surviving are his widow, three daughters, four sons, his mother, two sisters and two brothers.

Richard S. Knowlton, M. D., Cleveland; University of Rochester School of Medicine, 1933; aged 58; died February 18; member of the Ohio State Medical Association and the American Medical Association. A native of Mantau, Dr. Knowlton practiced for three decades in Cleveland. He also maintained a home in Ashtabula and did some practice there. He was a veteran of World War II, during which he served in the Army Medical Corps, and was a 32nd Degree Mason. Survivors include his widow and a brother, Dr. Edward A. Knowlton, of Mantau.

Jorge Anibal Leon, M. D., Columbus; medical degree from the University at Quito, Ecuador; aged 40; died February 14; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society. Dr. Leon was taking residency training in chest diseases as a member of the staff of Benjamin Franklin Hospital. He had previously engaged in the practice of internal medicine in Columbus. Survivors include his widow, three sons, his mother, and several brothers and sisters.

Edgar James March II, M. D., Canton; University of Rochester School of Medicine, 1941; aged 54; died February 20; member of the Ohio State Medical Association. A life resident of Canton, Dr. March began practice there in 1945. He was a veteran of World War II, during which he served in the Army Medical Corps. Affiliations included memberships in the Masonic Lodge and the Baptist Church. Surviving are his widow, three daughters and five sons.

Lester William McDevitt, M. D., Cincinnati; Harvard Medical School, 1921; aged 71; died February 3; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A physician



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and surgeon of long standing in Cincinnati, Dr. McDevitt's specialty was obstetrics and gynecology. He was a veteran of World War I, having volunteered as a fighter pilot with the British forces. Survivors include a daughter, a son, and a sister.

Isidora Baldovino Nonato, M. D., Cleveland; College of Medicine Southwestern University, the Philippines, 1963; aged 36; died February 14. Dr. Nonato came to Cleveland for advanced training after receiving her medical degree in the Philippines. She had only recently joined the staff of Evangelical Deaconess Hospital as an intern. She was married to Dr. Jose C. Nonato, a Manila physician who also was studying in Cleveland. He survives with an infant son.

John Dexter Osmond, Sr., M. D., Lyndhurst-Mayfield; Western Reserve University School of Medicine, 1909; aged 84; died February 17; member of the Ohio State Medical Association, the American Medical Association, American Roentgen Ray Society, Radiological Society of North America; diplomate of the American Board of Radiology. A practitioner of long standing in the Cleveland area, Dr. Osmond specialized in radiology, and was one of the few specialists in this field who served overseas in the Army Medical Corps during World War II. He was a charter member of the Cleveland Radiological Society and a former director of the Academy of Medicine of Cleveland. He was a past president of the Lions Club, past commander of the local American Legion post, a 32nd Degree Mason, and an elder in the Presbyterian Church. Survivors include a daughter and a son, Dr. John D. Osmond, Jr.

Alexander Pollak, M. D., Cleveland; medical degree from the university in Prague, 1923; aged 66; died February 9; former member of the Ohio State Medical Association and the American Medical Association. A former practitioner in Czechoslovakia, Dr. Pollak endured imprisonment in the Dachau Concentration Camp during World War II before he came to this country. His practice in Cleveland was in the field of general practice and internal medicine. His widow and a daughter survive.

Harry William Reck, M. D., Dayton; Ohio State University College of Medicine, 1917; aged 69; died February 19; member of the Ohio State Medical Association and former member of the American Medical Association. Dr. Reck interned at St. Elizabeth Hospital then went into service with the Army during World War I. He returned to Dayton after the war and practiced there until last year. In addition to his private practice, he was school physician for many years. A member of the American Legion and several Masonic bodies, he is survived by his widow and two daughters.

Carl Walker Sawyer, M. D., Marion; Rush Medical College, 1906; aged 84; died February 22; member of the Ohio State Medical Association, the American Medical Association, American Psychiatric Association, Central Neuropsychiatric Association; Fellow of the American College of Physicians; diplomate of the American Board of Psychiatry and Neurology. A physician of long standing in the Marion area, Dr. Sawyer was the son of the late Dr. Charles E. Sawyer, physician to President Warren G. Harding and founder of the Sawyer Sanatorium. Dr. Carl Sawyer's practice was largely associated with the sanatorium, but in addition to his professional associations, he was known as a writer, lecturer and historian. One of his most dedicated services in the community was that as president of the Harding Memorial Association. Closely associated in the practice and other activities of Dr. Sawyer is his surviving son, Dr. Warren C. Sawyer.

Edward Joseph Smyka, M. D., Lyons; St. Louis University School of Medicine, 1939; aged 52; died February 19. Dr. Smyka had opened an office in the Lyons community only a few months ago, after moving there from Detroit. He is survived by his widow and two children.

Chester Paul Widmeyer, M. D., Akron; Ohio State University College of Medicine, 1941; aged 59; died December 30; member of the Ohio State Medical Association and the American Academy of General Practice; former member of the American Medical Association. A general practitioner in Akron, Dr. Widmeyer began practice there after serving in the Army Medical Corps during World War II.

James Rucker Williams, M. D., Pueblo, Colorado; University of Cincinnati College of Medicine, 1947; aged 41; died February 14. A former resident of Cincinnati, Dr. Williams left the state after receiving his medical degree. His specialty field was neurosurgery. His widow, three children, his parents, and a sister survive.

OSU School of Nursing Is Given Federal Grant for Building

The Ohio State University School of Nursing has received a $1,165,000 construction grant from the U. S. Public Health Service to help finance a new building.

Total cost for the building is estimated at $2,170,000 with $1,000,000 already earmarked for the project from the 1963 bond issue approved by Ohio voters.

The building will be located on Neil Avenue between 9th and 10th Avenues. It will be a three-story structure, with the basement used for lockers, a student lounge and service areas.

The new building will permit the School of Nursing to increase student capacity from 231 to 308 students for the entering class.

Construction will begin in 1966, with occupancy planned for 1967.



Frank E. Foss, M. D., Toledo, left, and Nicholas H. Holmes, M. D., Chillicothe, center, discuss plans for the Ohio State Surgical Association annual meeting in Cleveland Thursday and Friday, May 26th and 27th, with Robert G. Smith, M. D., Circleville, President. This is the second year the surgical group has met in conjunction with OSMA. OSSA is sponsoring the appearance of Thomas L. Dwyer, Mexico, Mo., president of the Association of American Physicians and Surgeons, at a banquet in Cleveland Room of the Sheraton Cleveland Hotel on Thursday evening which is open to non-members by preregistration. A registration form appears elsewhere in this issue.

Heart Association Luncheon Speaker Will Be Noted Cardiologist

Lewis E. January, M. D., president-elect of the American Heart Association and professor of internal medicine (cardiology), University of Iowa, will be the luncheon speaker at the Annual Meeting of the Ohio State Heart Association to be held Wednesday, May 25, at the Pick-Carter Hotel in Cleveland.

The theme of the all-day meeting for heart volunteers throughout the state will be "Heart Attack and Stroke Risk Reduction."

All interested physicians are invited to hear Dr. January at the luncheon session and can get further information on this meeting by contacting the Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215.

Caribbean Territories Sales Group Gets Cease and Desist Order

The Division of Securities, Department of Commerce of the State of Ohio, has issued a cease and desist order in the matter of the solicitation for sale of unregistered interest in foreign real estate located in the Caribbean Territories and the Bahamas to Ohio residents in Ohio by Trans Caribbean Research Corp., 4333 St. Catherine Street West, Montreal, Quebec.

Fellowships in Immunology-Allergy Announced at Cincinnati U

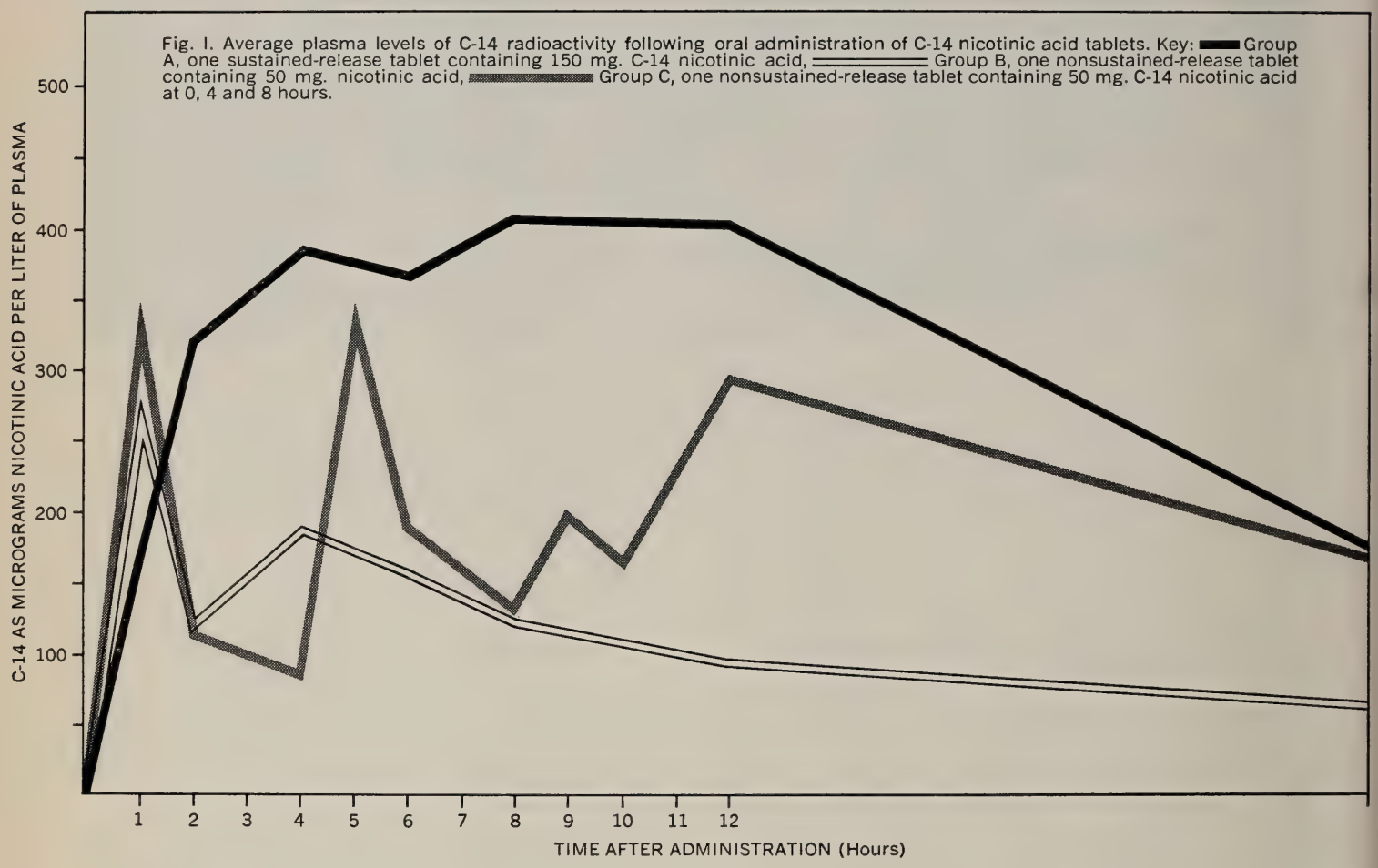
A New Fellowship training program in Immunology and Allergic Diseases will begin July 1, 1966, under the auspices of the Division of Immunology of the Department of Medicine, College of Medicine of the University of Cincinnati. The program is a combined clinical and research training experience for a minimum of two years. Prospective applicants may choose a two-year training program in allergic diseases or a two-year training program in rheumatology. Applicants should have a minimum of two years' training in either internal medicine or pediatrics.

The Fellowship is part of a National Institutes of Health training award and the annual stipend begins at $6000.00 per year. Further information may be obtained by writing to Dr. I. Leonard Bernstein, 19 Garfield Place, Cincinnati, Ohio 45202 (Allergy Program), or to Dr. Evelyn Hess, Cincinnati General Hospital, Cincinnati, Ohio 45229 (Rheumatology Program).

Health insurance policies cover about 78 per cent of the U. S. population. Benefits paid on these policies reached $8.6 billion in 1964. Government programs in 1964 paid about $1.2 billion in health aid to the vendors of health services.

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▒▒▒ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

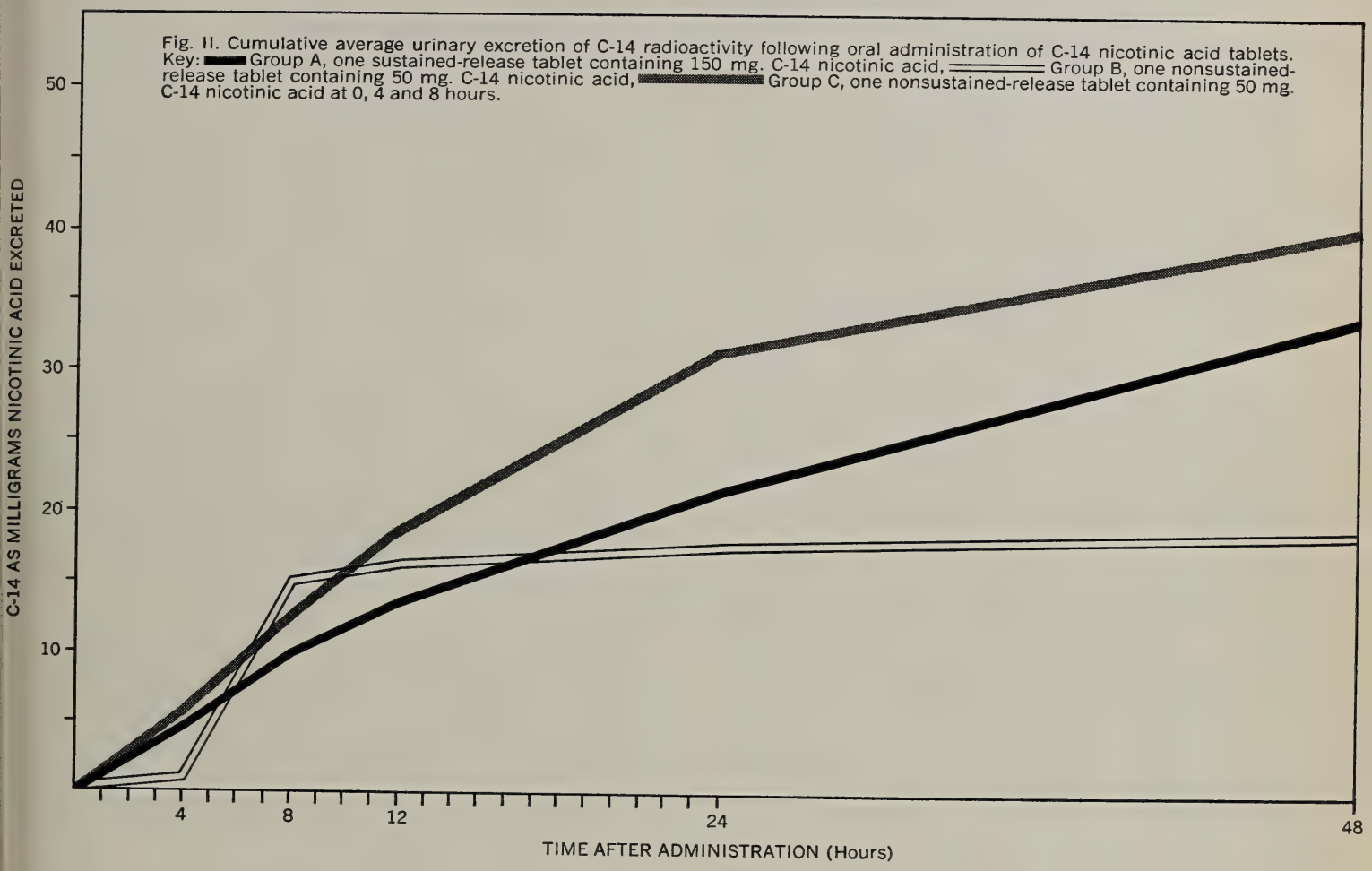
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Activities of County Societies . . .

First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

CLERMONT

An overall determination of all Clermont County Health needs has been undertaken by the Clermont County Medical Society.

Dr. Albert W. VanSickle, Clermont County Health Commissioner, has been named chairman of a committee of four doctors who have been assigned the job of obtaining the extensive health survey. Serving with him are Dr. Phillips Greene; Dr. Kirby Lancaster, who is a member of the County Board of Health; and Dr. Lee Davidson.— *The Clermont Sun.*

HAMILTON

"Non-Cardiac Chest Pain" was the topic of a panel discussion for the February 15 meeting of the Academy of Medicine of Cincinnati.

Guest participants were Dr. Edmund Pellegrino, professor and chairman of the Department of Medicine, University of Kentucky School of Medicine, moderator;

Dr. Philip Tumulty, professor of medicine, Johns Hopkins University School of Medicine; and

Dr. Morton Bogdonoff, professor of medicine, Duke University School of Medicine.

* * * *

A joint meeting of the Academy and the Cincinnati Bar Association was held on February 22 at the Netherland Hilton Hotel. The meeting followed a social hour and dinner.

Topic for discussion was "The Doctor's Patients Are the Lawyer's Clients." Principal speaker was the honorable Felix Forte, senior member of the Appellate Division of the Superior Court of Massachusetts, and Professor Emeritus, Boston University School of Law.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

CLARK

A vigorous campaign to combat the growing rate of venereal disease in Clark County was launched by the Clark County Medical Society in conjunction with an official proclamation from Mayor Robert C. Henry.

The mayor designated a week in February as "Venereal Disease Week" to add emphasis to the campaign.

The proclamation stated venereal diseases are the nation's leading communicable disease, and are increasing in scope with a reported 23,250 cases throughout the nation during 1965.

Plans have been made locally by the Clark County Medical Society, Jaycees and other interested persons to eliminate the ignorance surrounding the diseases.— Adopted from the *Springfield News-Sun.*

* * *

The Executive Director of the American College of Physicians, Dr. Edward C. Rosenow, Jr., Philadelphia, Pa., was guest speaker at the February 21 meeting of the Clark County Medical Society. The dinner meeting was held in the Shawnee Hotel, Springfield. His topic was "Medical Communications."

GREENE

Dr. John Matre, chief of gastroenterology at the Veterans Administration Hospital, Dayton, presented a lecture on liver biopsy to members of the Greene



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MEMBER: *American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association*

County Medical Society Thursday morning (Feb. 10) in the Greene Memorial Hospital Auditorium.

County Commissioners James Ford, Ray Durnbaugh and Ralph Mitman, and Fred Tartaglia, hospital administrator, were special guests.

Discussion was held on a radio program which the society is sponsoring. Entitled "Know Your Doctor," presented over Radio Station WGIC the third Thursday of each month from 9:30 to 10 a. m. — *Xenia Daily Gazette.*

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

WOOD

A report on the most recent methods of handling tuberculosis was given by Dr. Robert Markey at the Wood County Medical Society meeting Thursday night (February 17).

Dr. Markey stated that the number of new cases in Wood County is very low.

New drugs have shortened hospital stays and improved cure rates in tuberculosis treatment.

Dr. Marjorie Conrad was introduced to the membership of the Wood County Medical Society. — *Daily Sentinel Tribune, Bowling Green.*

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

The Mahoning County Medical Society recently presented copies of *Today's Health Guide,* to the libraries of 26 schools, which included every high school in Mahoning County, Youngstown University, and three nearby schools in Trumbull County.

Arrangements for the gift were made by the Society's public relations committee. Dr. Robert L. Jenkins, committee member, made the presentation. The books were formally accepted in a brief ceremony by representatives of the Mahoning County and Youngstown Boards of Education, the Youngstown Diocese, and Youngstown University.

The Mahoning County Medical Society has also ordered an additional six copies of the book to be given as prizes in the tri-county spelling bee conducted by the *Youngstown Vindicator.*

Each book carried a special book-plate marking it as a presentation from the Medical Society.

The annual banquet of the Mahoning County Medical Society was held on January 25 to honor retiring president, Dr. John J. McDonough. He was presented an appreciation plaque. New officers installed at the dinner-dance were: Dr. F. A. Resch, president; Dr. H. J. Reese, president-elect, Dr. C. K. Walter, secretary; and Dr. M. C. Raupple, treasurer. Dr. Edwin R. Westbrook, Sixth District Councilor, presented the OSMA fifty-year certificate and pin to Dr. W. K. Allsop. Special guests were members of the Corydon Palmer Dental Society and their wives. Dr. Henry L. Shorr was program chairman.

The benefits and responsibilities of Social Security were explained at the February 15 meeting of the Mahoning County Medical Society. Speaker was William J. McCauley, district manager of the Youngstown Social Security office. Arrangements were made by Dr. Jack Schrieber, program chairman.

STARK

Dr. A. Dixon Weatherhead, chief of the Cleveland Clinic's Department of Psychiatry, was speaker for the Stark County Medical Society meeting on February 10 at Mergus Restaurant, Canton. His topic was "The Management and Treatment of Depression."

SUMMIT

The second annual Northeast Ohio Sports Injuries Conference will be held in Akron on Saturday, April 16.

Sponsors of the meeting are Summit County Medical Society and the American Academy of Orthopedic Surgeons. The University of Akron will be host for the gathering to which physicians and the coaching, training and athletic teaching personnel of high schools have been invited.

The all day series of lectures, panels, exhibits and discussions will be aimed at the problem of injuries to particularly the participant in intramural and required athletics as well as at those of the varsity ath-

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lete. — Adapted from *Evening Independent,* Massillon.

Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

TUSCARAWAS

Dr. Robert Hopkins, Cleveland, spoke on the topic, "Pulmonary Embolism — Its Diagnosis and Treatment," during the February meeting of the Tuscarawas County Medical Society at Bonvechio's in Wainwright.

Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, M. D., ZANESVILLE)

WASHINGTON

Dr. Karl P. Klassen, president and trustee of Central Ohio Heart Association, professor of surgery and director of the Division of Thoracic Surgery at Ohio State College of Medicine, spoke on the diagnosis and surgical treatment of coronary artery disease at the monthly meeting of Washington County Medical Society.

Dr. W. F. Rogers and Dr. Robert Biddle of Parkersburg were guests at the meeting which was attended by 19 members. Dr. Mary Whitacre Owen, president of the Washington County Society, presided.

The program was sponsored by the Central Ohio Heart Association as part of heart month. — *Marietta Daily Times.*

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

HOLMES

Dr. Charles H. Hart, president of the Holmes County Medical Society, announced that annual awards of $50 each will be given to an outstanding senior member of the Future Nurses Clubs at Hiland and West Holmes High Schools.

It is the hope of the medical society that these annual awards may encourage students, both boys and girls, to join the Future Nurses Clubs and to make application for training in nursing.

To qualify for the award, a student must have made application for nurse's training, but need not have already been accepted by a school of nursing. The winners of the awards will be announced during the high school graduation ceremonies, Dr. Hart said. — *News-Journal,* Mansfield.

LORAIN

A record attendance marked the regular meeting of Lorain County Medical Society on Tuesday evening, March 8, when members and their wives met to hear the featured speaker of the evening, Charles L. Hudson, M. D., of Cleveland, President-Elect of the American Medical Association. Among guests present were Mrs. Hudson, William R. Schultz, M. D., of Wooster — Eleventh District Councilor — and Mrs. Schultz, and H. T. Pease, M. D., of Wadsworth, who had previously served as Councilor.

The dinner was preceded by a social hour, and following a brief business session and reports, President Joseph A. Cicerrella, M. D., introduced Dr. Hudson. In welcoming the speaker, Dr. Cicerrella recalled the fact that this was not the first occasion on which Dr. Hudson had addressed the Lorain County Medical Society. While President of Ohio State Medical Association, Dr. Hudson had spoken to the group in September 1955, and his subject then was "The Changing Picture of the Practice of Medicine."

His present topic outlined the effect of the 1965 Social Security Amendments on Medical Practice. Advances in the mechanism used to provide payment for medical care challenges the future of the American system, and in accepting the challenge, the individual physician should establish and hold fast to the principle that the Government should provide assistance only for the needy.

In a cordial vote of thanks, Dr. Cicerrella expressed the members' pleasure in welcoming Dr. and Mrs. Hudson. This was a "first" for the Society, in that it was the first occasion a President-Elect of the American Medical Association had addressed the group. The local press was well represented at the meeting.

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Woman's Auxiliary Highlights ...

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

LAST YEAR, the Woman's Auxiliary to the Ohio State Medical Association celebrated its twenty-fifth anniversary. It was a momentous occasion. But this year — our twenty-sixth — is equally so. Because our parent organization has seen fit to honor us with a coveted invitation — the privilege of attending OSMA's General Sessions on Wednesday, Thursday and Friday afternoons of convention week — May 24 through 27 at the Sheraton-Cleveland Hotel.

How to put into words what such a magnificent gesture means? Always, to be sure, the doctors have given us outstanding cooperation, significant understanding and unlimited help. That, now, they should want us, as a body, to attend three of their very important General Sessions would indicate (at least so it appears to this reporter) that there is an ever-growing awareness of the tremendous potential of the Woman's Auxiliary yet to be tapped. Certainly there is no end to what we are willing, eager and happy to do. For us, it is a privilege to serve the medical profession in any way we can. We thank the doctors of Ohio for permitting us that privilege.

What are those three sessions I've been dangling so temptingly? The first is Wednesday, May 25: "Problems in Marriage," sponsored by the Section on Psychiatry and Neurology, the Ohio Psychiatric Association and cosponsored by the OSMA Committee on Medicine and Religion. The second session is on Thursday, May 26, with Dr. Charles L. Hudson, President-Elect of the American Medical Association, as the featured speaker. He will present detailed information regarding the rules and regulations of Public Law 89-97, which becomes effective July 1, 1966. Dr. Hudson has participated in the activities of the AMA's Task Force in its consultations with the Federal Government on the development of these rules and regulations. He will answer questions from the audience following his formal presentation.

The third session is on Friday, May 27, and the provocative theme "Care of the Patient: 1966" will be discussed by the well-known Dr. Edward R. Annis, Past President of the American Medical Association. He will take a look at the future of patient care and the effect of the various pieces of Federal legislation upon the traditional physician-patient relationship. A question and answer period will follow Dr. Annis' formal presentation.

All three sessions will begin promptly at 1:30 P. M. and it should go without saying (except that I feel I must say it!) that our Auxiliary members honor the request of the doctors that we be in our seats at the appointed time.

Busy Women and Events

A salute to two busier-than-bees **Cuyahoga County** women — Mrs. Burdette Wylie and Mrs. Roscoe Kennedy. They are chairman and cochairman respectively of this twenty-sixth annual meeting. Can you begin even to imagine the amount of work such a meeting entails? (It leaves me weak, just thinking about it!)

The detailed program for our convention is on page 372, but I should like to highlight a few of the "Newer Looks" that will be yours, if you come to Cleveland in May. A Buffet Breakfast for the doctors and their wives will be given on Friday, May 27, from 7:30 A. M. to 8:45 A. M. (Because of our participation in the men's General Sessions program, our luncheon hours have necessarily been shortened and revamped, as have certain other procedures of the past). But to get back to THAT Breakfast — Higbee's will present a Fashion Show and this you'll hardly believe: Local doctors will be the models! I'm told further that Chairmen Mrs. Joseph Corsaro, Mrs. Leonard Backiel, and Mrs. T. L. Manning will appear in chefs' outfits and that it will all be a "fun affair."

Ever heard of Hixon's Barn? As fascinating as anything this side of the Rockies! It is a unique shop and display room and features an old-fashioned Ice Cream Parlor (in operation), an old-fashioned Grocery Store, antiques, floral arrangements, hand-dipped candles, handmade candies — come on in and see for yourselves. You can purchase or you can just observe. Transportation to the Barn will be made available from 5:30 P. M. to 7.30 P. M. on Wednesday and Thursday, May 25 and 26. Interested persons (the men are equally welcome) should contact Information Chairman Mrs. Frederick Rittinger. Mrs. John Sanders is general chairman of the Hixon's Barn project — something you just won't want to miss.

Lunch-a-la-cart?

On Friday, May 27, at 12:00 NOON, immediately following the installation of officers, "French Maids"

(so says my copy) will serve "Happy Time" punch from carts. Another first in luncheons that day — "Lunch-On-A-Cart" will honor the new officers, members and honored guests. I'm just as curious as you. But it **is** something to look forward to, don't you think? Mrs. Edward F. Kieger is chairman and Mrs. John Budd cochairman of that New Look in luncheons. On Thursday, May 26, also at 12:00 NOON, the **Lake County** Auxiliary will hostess a luncheon, honoring our past state presidents and incumbent county presidents. Mrs. Frederick W. Wachter is chairman and Mrs. Lloyd E. Johnson cochairman of that special event.

Mrs. Reuben R. Gould, convention publicity chairman, advises me that all corsages and center pieces are being handmade and that the money usually allotted for this expense will be donated to AMA-ERF. Mrs. Kenneth Potter is chairman of this interesting project and Mrs. R. H. McDonald cochairman. And to add to all that — some 15 women are involved in a French Reading Class to make boutonnieres that will serve as favors for special guests. Cochairmen for that unusual activity are Mrs. John B. Hazard and Mrs. Joseph Corsaro.

Counties on Display

A huge display area is being reserved in a section of the Main Exhibit Hall for local county exhibits. You may have an outstanding project to feature — or maybe even more than one. And these invaluable scrapbooks! What a wonderful opportunity to show what you have all been doing — and at the same time to observe, get ideas and learn from others. Exhibitors are asked to contact Mrs. Charles A. Swan, 2680 North Moreland Boulevard, Cleveland 44120, as to how much space you would like reserved for your county. Another point of emphasis: once again the annual meeting will feature the county reports. This year, the session will be on Wednesday, May 25, from 3:00 to 5:00 P. M. Every county president should consider it a privilege to be able to present a view of her group's activities. Set in proper focus, it can tell a most meaningful story.

Auxiliary headquarters will be at the Sheraton-Cleveland and if you haven't already done so, you'd better make that hotel reservation on the double. The Statler-Hilton and the Pick-Carter are two other Cleveland hotels and there are a number of motor hotels: Lake Erie Motel, Sahara Motor Hotel and the Versailles Motor Inn. (This list isn't complete by any means.)

My Apologies

Convention news has had to take precedence over local auxiliary news this month. I promise to make up for it in the next issue. So keep those clippings coming in to me, because I DO want them and I WILL use them.

CREDIT JUDGMENT



would be easy if you knew all about everyone

Even in small towns, acquaintanceship just won't do in credit judging today. Credit buying is done too quickly . . . there's so much more of it . . . the auto takes families to neighboring cities for credit buying.

So how can you hope to know all the credit facts about everyone — car loans, home loans, medical bills, out-of-town time purchases? **You can know through your local credit bureau.** And by knowing, you can save hours of credit pondering, save time and expense of trying to collect poor risks, save losses.

Your local credit bureau's up-to-the-minute family credit records are augmented by those of eighty-six Ohio member bureaus, and by the records of over two-thousand such bureaus in the U.S. We will gladly direct you to that bureau.

ASSOCIATED CREDIT BUREAUS OF OHIO

P. O. Box 1114, Lima, Ohio 45802

State Association Officers and Committeemen

Headquarters Office: Room 1005, 79 East State Street, Columbus 43215. *Telephone 221-7715*

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1058 Hanna Bldg., Cleveland 44115

Lawrence C. Meredith, *President-Elect*
205 Elyria Block, Elyria 44035

Robert E. Tschantz, *Past-President*
515 Third Street, N. W., Canton 44703

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First District, Robert E. Howard, 2600 Union Central Bldg., Cincinnati 45202; **Second District,** Theodore L. Light, 2670 Salem Ave., Dayton 45406; **Third District,** Frederick T. Merchant, 1051 Harding Memorial Pky., Marion 43305; **Fourth District,** Robert N. Smith, 3939 Monroe St., Toledo 43606; **Fifth District,** P. John Robechek, 10525 Carnegie Ave., Cleveland 44106; **Sixth District,** Edwin R. Westbrook, 438 North Park Ave., Warren; **Seventh District,** Benj. C. Diefenbach, 30 S. 4th St., Martins Ferry; **Eighth District,** Robert C. Beardsley, 2236 Maple Ave., Zanesville; **Ninth District,** George N. Spears, 2213 So. Ninth St., Ironton; **Tenth District,** Richard L. Fulton, 1211 Dublin Rd., Columbus 43212; **Eleventh District,** William R. Schultz, 1749 Cleveland Rd., Wooster 44691.

COMMITTEES

Committee on Education—Thomas E. Rardin, Columbus, Chairman (1966); Clyde W. Muter, Warren (1970); Thomas S. Brownell, Akron (1969); John G. Sholl, Cleveland (1968); Elmer R. Maurer, Cincinnati (1967).

Judicial and Professional Relations Committee—Frank F. A. Rawling, Toledo, Chairman (1968); Homer A. Anderson, Columbus (1970); Chester H. Allen, Portsmouth (1969); David Fishman, Cleveland (1967); Paul A. Mielcarek, Cleveland (1966).

Committee on Public Relations and Economics—Frederick P. Osgood, Toledo, Chairman (1969); Luther W. High, Millersburgh (1970); John H. Budd, Cleveland (1968); John J. Cranley, Cincinnati (1967); Horace B. Davidson, Columbus (1966).

Committee on Scientific Work—Samuel Saslaw, Columbus, Chairman (1968); Jack Schreiber, Canfield (1970); Walter J. Zeiter, Cleveland (1970); John D. Battle, Jr., (1969); Harold J. Schneider, Cincinnati (1969); Isador Miller, Urbana (1968); William Hamelberg, Columbus (1967); F. A. Simeone, Cleveland (1967); Ralph K. Ramsayer, Canton (1966); G. Douglas Talbott, Dayton (1966).

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Committee on Eye Care—Arthur D. Collins, Cleveland, Chairman; Martin J. Cook, Springfield; Thomas L. Edwards, Lima; Robert H. Magnuson, Columbus; Russell J. Nicholl, Cleveland; Claude S. Perry, Columbus; Norman W. Pinschmidt, Gallipolis; Barnet R. Sakler, Cincinnati; Robert L. Willard, Toledo.

Committee on Hospital Relations—William R. Schultz, Wooster, Chairman; L. A. Black, Kenton; L. Fred Bissell, Aurora; Oscar W. Clarke, Gallipolis; Robert M. Craig, Dayton; John V. Emery, Willard; Harvey C. Gunderson, Toledo; Philip B. Hardymon, Columbus; Middleton H. Lambright, Cleveland; Lloyd E. Larrick, Cincinnati; Joseph S. Lichty, Akron; James C. McLarnan, Mt. Vernon; Ben V. Myers, Elyria; Robert A. Tennant, Middletown; V. William Wagner, Port Clinton; William A. White, Canton.

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Committee on Legislation—James T. Stephens, Oberlin, Chairman; Donald R. Brumley, Findlay; George D. J. Griffin, Cincinnati; Jack L. Kraker, Lancaster; Maurice F. Lieber, Canton; Ralph F. Massie, Ironton; James C. McLarnan, Mt. Vernon; Robert E. Rinderknecht, Dover; John H. Sanders, Cleveland; Carl R. Swanbeck, Sandusky; William W. Trostel, Piqua.

Committee on Maternal Health—Anthony Ruppersberg, Columbus, Chairman; Otis G. Austin, Medina; Raymond E. Barker, Columbus; William D. Beasley, Springfield; Keith R. Brandeberry, Gallipolis; Thomas E. Byrne, Mentor; C. Raymond Crawley, Dover; Mel A. Davis, Columbus; Marion F. Detrick, Jr., Findlay; John P. Garvin, Columbus; Richard P. Glove, Cleveland; Robert A. Heilman, Columbus; John F. Hillabrand, Toledo; Robert E. Johnstone, Cincinnati; Albert A. Kunnen, Dayton; James F. Morton, Zanesville; Ralph K. Ramsayer, Canton; Robert E. Swank, Chillicothe; Densmore Thomas, Warren; Robert S. VanDervort, Elyria.

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Committee on Mental Health—Wendell A. Butcher, Columbus, Chairman; Homer A. Anderson, Columbus; Max D. Graves, Springfield; Charles W. Harding, Worthington; Warren G. Harding, II, Columbus; Henry L. Hartman, Toledo; J. Robert Hawkins, Cincinnati; William H. Holloway, Akron; Nathan B. Kalb, Lima; Thomas E. Rardin, Columbus; Philip C. Rond, Columbus; Victor M. Victoroff, Cleveland; John A. Whieldon, Columbus.

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Military Advisory Committee—Drew L. Davies, Columbus, Chairman; A. A. Brindley, Maumee; Ralph G. Carothers, Cincinnati; Homer D. Cassel, Dayton; Henry A. Crawford, Cleveland; Walter L. Cruise, Zanesville; Charles R. Keller, Mansfield; Ralph W. Lewis, Portsmouth; Edward L. Montgomery, Circleville; Frank T. Moore, Akron; Earl Rosenblum, Steubenville.

Committee on Occupational Health—Rex H. Wilson, Akron, Chairman; Drew J. Arnold, Columbus; William W. Davis, Columbus; Winfred M. Dowlin, Canton; Harold M. James, Dayton; H. W. Lawrence, Middletown; Daniel M. Murphy, Marion; Anthony M. Puleo, Cleveland; George W. Wright, Cleveland; H. P. Worstell, Columbus.

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Committee on Radiation—Charles M. Barrett, Cincinnati, Chairman; Eldred B. Heisel, Columbus; George F. Jones, Lancaster; Carey B. Paul, Jr., Columbus; Thomas C. Pomeroy, Columbus; Denis A. Radefeld, Lorain; Eugene L. Saenger, Cincinnati; Robert E. Schulz, Wooster; John P. Storaasli, Cleveland; Robert P. Ulrich, Troy; Robert L. Wall, Columbus; John Robert Yoder, Toledo; James G. Kereiakes, Ph. D. (Advisory Member, Special Consultant), Cincinnati.

Committee on Rural Health—Robert E. Reiheld, Orrville, Chairman; Chester J. Brian, Eaton; J. Martin Byers, Greenfield; Walter A. Campbell, Coshocton; E. Joel Davis, East Canton; Victor R. Frederick, Urbana; Benjamin W. Gilliotte, Zanesville; Jerry L. Hammon, West Milton; Jasper M. Hedges, Circleville; Luther W. High, Millersburg; E. D. Mattmiller, Athens; John R. Polsley, North Lewisburg; Leonard S. Pritchard, Columbiana; Harold C. Smith, Van Wert; Kenneth W. Taylor, Pickerington; Edmond K. Yantes, Wilmington.

Committee on Scientific and Educational Exhibit—Charles V. Meckstroth, Columbus, Chairman; Harvey C. Knowles. Jr., Cincinnati; W. Arnold McAlpine, Toledo; Arthur E. Rappoport, Youngstown; Arnold M. Weissler, Columbus; Walter J. Zeiter, Cleveland; Robert E. Zipf, Dayton.

Committee on School Health—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Paul D. Hahn, New Philadelphia; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Lawrence L. Maggiano, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Albert E. Thielen, Cincinnati; Homer B. Thomas, Gallipolis.

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OSMA Members of the Joint Advisory Committee on Athletic Injuries—Robert J. Murphy, Columbus; John R. Jones, Toledo; Sol Maggied, West Jefferson; Charles H. McMullen, Loudonville; Carey B. Paul, Jr., Columbus; Thomas E. Shaffer, Columbus; Don A. Kelly, Cleveland; Marvin R. McClellan, Cincinnati; Walter A. Hoyt, Jr., Akron.

OSMA Members of the Joint Committee on School Bus Driver Examinations—Carey B. Paul, Jr., Columbus; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus.

DELEGATES AND ALTERNATES

Delegates and Alternates to the American Medical Association—George W. Petznick, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Theodore L. Light, Dayton; Kenneth D. Arn, Dayton, alternate; Edmond K. Yantes, Wilmington; Harry K. Hines, Cincinnati, alternate; John H. Budd, Cleveland; P. John Robechek, Cleveland, alternate; Richard L. Meiling, Columbus; Robert E. Tschantz, Canton, alternate; Frederick F. Osgood, Toledo; Robert N. Smith, Toledo, alternate; Charles A. Sebastian, Cincinnati; J. Robert Hudson, Cincinnati, alternate; Edwin H. Artman, Chillicothe; Philip B. Hardymon, Columbus, alternate.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES

First District

Councilor: Robert E. Howard, Cincinnati 45202
2600 Union Central Bldg.

ADAMS—Gary J. Greenlee, President, Manchester 45144; Stanley H. Title, Secretary, Manchester 45144.

BROWN—Charles H. Maly, President, Sardinia 45171; Charles W. Hannah, Secretary, Sardinia 45171. 1st Monday monthly.

BUTLER—Robert Johnson, President, 500 S. Breiel Boulevard, Middletown 45042; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 4th Wednesday monthly.

CLERMONT—Cecil F. Barber, President, State Route 133, Felicity 45120; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond 45157. 3rd Wednesday monthly, except July and August.

CLINTON—Richard R. Buchanan, President, 115 West Main, Wilmington 45177; Mary Ranz Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Robert M. Woolford, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Monthly meeting dates, 1st Tuesday; Academy, 3rd Tuesday, except June, July and August.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Walter Felson, Secretary, 357 South St., Greenfield 45123. 3rd Tuesday bimonthly.

WARREN—O. Williard Hoffman, President, 20 East Fourth Street, Franklin 45005; Ray E. Simendinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: Theodore L. Light, Dayton 45406
2670 Salem Ave.

CHAMPAIGN—Myron J. Towle, President, 848 Scioto Street, Urbana 43078; Fred R. Denkewalter, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—Henry M. Tardif, President, 2608 E. High Street, Springfield 45505; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield 44501. 3rd Monday monthly, except June, July and August.

DARKE—William A. Browne, President, 722 Sweitzer St., Greenville 45331; Delbert D. Blickenstaff, Secretary, 552 S. West St., Versailles 45380. 3rd Tuesday monthly.

GREENE—Clement G. Austria, President, 1142 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly except July and August.

MIAMI—David Brown, President, 1060 North Market Street, Troy 45373; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua 45356. 1st Tuesday monthly.

MONTGOMERY—Charles E. O'Brien, President, 600 Fidelity Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly October through May — 1st Wednesday June.

PREBLE—John D. Darrow, President, 228 N. Barron St., Eaton 45320; Willard C. Clark, Jr., Secretary, 228 N. Barron, Eaton 45320. Irregular meetings.

SHELBY—George J. Schroer, President, 322 Second Ave., Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney 45365.

Third District

Council: Frederick T. Merchant, Marion 43305
1051 Harding Memorial Pky.

ALLEN—Carl H. Zinsmeister, President, 729 W. Market Street, Lima 45801; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly.

AUGLAIZE—Robert Sobocinski, President, 75 Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring Street, St. Marys 45885. 1st Thursday monthly except July.

CRAWFORD—Don E. Ingham, President, 201 N. Market Street, Galion 44833; Johnson H. Chow, Secretary, 1040 Devonwood Drive, Galion 44833. Called meetings.

HANCOCK—Raymond J. Tille, President, 801 S. Main St., Findlay 45840; Herbert L. Queen, Secretary, 828 Woodworth Dr., Findlay 45840.

HARDIN—William D. Dewar, President, 405 North Main Street, Kenton 43326; John J. Roget, Secretary, Belle Center 43310. 2nd Tuesday monthly.

LOGAN—Thomas Seitz, President, 223 E. Columbus Street, Bellefontaine 43311; Glen Miller, Secretary, R. D. 2, West Liberty 43357. 1st Friday monthly.

MARION—Ransome Williams, President. 1035 Harding Memorial Parkway, Marion 43302; Alice Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—R. Duane Bradrick, President, Rockford 45882; R. L. Dobbins, Secretary, 5402 State Route 29 East, Celina. 3rd Thursday, monthly.

SENECA—Olgierd C. Garlo, President, 53 Clay Street, Tiffin 44883; Leonard M. Gaydos, Secretary, 233 South Monroe Street, Tiffin 44883. 3rd Tuesday monthly.

VAN WERT—Norman L. Marxen, President, Medical Arts Bldg., Fox Road, Van Wert 45891; W. L. Iler, Secretary, Medical Arts Bldg., Fox Road, Van Wert 45891. 4th Friday monthly.

WYANDOT—Herschel A. Rhodes, President, 777 N. Sandusky Ave., Upper Sandusky 43351; J. J. Browne, Secretary, 777 N. Sandusky Ave., Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—L. F. Berry, Jr., President, 1400 East Second Street, Defiance 43512; W. S. Busteed, Secretary, Box 218, Defiance 43512.

FULTON—B. H. Reed, Jr., President, Delta 43515; R. L. Davis, Secretary, Wauseon 43567. 2nd Tuesday quarterly March, June, September, December.

HENRY—J. J. Harrison, President, 113 East Clinton Street, Napoleon 43545; Gamble S. Hall, Secretary, 834 Strong Street, Napoleon 43545. 1st Tuesday monthly.

LUCAS—E. L. Doermann, President, 2001 Collingwood Blvd., Toledo 43620; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday monthly except July and August.

OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.

PAULDING—Roy R. Miller, President, 220 W. Perry, Paulding 45879; D. Paul Ward, Secretary, Box 416, Oakwood 45873. Meetings called.

PUTNAM—Arthur P. Daniel, President, 144 N. Walnut, Ottawa 45875; Oliver N. Lugibihl, Secretary, Pandora 45877. 1st Tuesday monthly.

SANDUSKY—J. L. Zimmerman, President, Memorial Hospital of Sandusky County, Fremont 43420; Mrs. Patsy J. Askins. Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.
WILLIAMS—John E. Moats, President, Central Drive, Bryan 43506; Neil T. Levenson, Secretary, 907 Noble Drive, Bryan 43506. 2nd Tuesday monthly.
WOOD—Roger A. Peatee, President, 140 S. Prospect Street, Bowling Green 43402; William B. Elderbrock, Secretary, Health Service, Bowling Green State University, Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44106
10525 Carnegie Ave.

ASHTABULA—J. R. Nolan, President, 2736 Lake Avenue, Ashtabula 44004; Richard Millberg, Secretary, 430 West 25th Street, Ashtabula 44004. 2nd Tuesday monthly.
CUYAHOGA—William F. Boukalik, President, 20030 Scottsdale Boulevard, Cleveland 44122; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.
GEAUGA—Bruce F. Andreas, President, 400 Downing Drive, Chardon 44024; Arturo J. Dimaculangan, Secretary, 8400 Mayfield Road, P. O. Box 277, Chesterland 44026. 2nd Friday monthly.
LAKE—Robert W. Colopy, President, 89 E. High Street, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening monthly, January, May, March, September and November unless otherwise ordered by Council.

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

COLUMBIANA—Edith S. Gilmore, President, 432 W. 5th St., E. Liverpool 43920; Fraser Jackson, Secretary, 205 W. 6th St. 3rd Tuesday monthly.
MAHONING —F. A. Resch, President, Doctors Park, Canfield 44406; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly except July and August.
PORTAGE—David Palmstrom, President, 124 North Prospect Street, Ravenna 44266; William R. Brinker, Secretary, 141 East Main Street, Kent 44240. 3rd Tuesday monthly.
STARK—A. R. Furnas, Jr., President, 420 Lake Avenue, N. E., Massillon 44646; Mr. John H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.
SUMMIT—James G. Roberts, President, 655 West Market Street, Akron 44303; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, 159 South Main Street, Akron 44308. 1st Tuesday monthly.
TRUMBULL—John F. McGreevey, President, 297 Hawthorne Lane N. E., Warren 44484; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly September through May.

Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry 43935
30 S. 4th St.

BELMONT—James Sutherland, President, 9 North 4th Street, Martins Ferry 43935; Bertha M. Joseph, Secretary, 100 South 4th Street, Martins Ferry 43935. 3rd Thursday of February, March, April, June, September, October, November and December.
CARROLL—Glen C. Dowell, President, 207 West Main, Carrollton 44615; Thomas J. Atchison, Secretary, 292 East Main, Carrollton 44615. 1st Thursday monthly.
COSHOCTON—Don Warren, President, 600 East Main Street, West Lafayette 43845; Harold Lear, Secretary, 133 South Fourth Street, Coshocton 43812. 2nd Tuesday monthly.
HARRISON—Charles D. Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988, Quarterly.
JEFFERSON—Jacob R. Cohen, President, 341 Market Street, Steubenville 43952; Irving Dreyer, Secretary, Ohio Valley Hospital, Steubenville 43952. 4th Tuesday monthly except December, January, February.
MONROE—Byron Gillespie, Secretary, Woodsfield 43793.
TUSCARAWAS—Robert J. Kuba, President, 319 Grant St., Dennison 44621; Thomas E. Ogden, Secretary, 138 E. Main St., Gnadenhutten. 2nd Thursday monthly.

Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705
2236 Maple Ave.

ATHENS—D. R. Johnson, President, 52 West Washington Street, Nelsonville 45764; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday monthly except July and August.
FAIRFIELD—George W. LeSar, President, 216 Harmon Avenue, Lancaster 43130; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore 43105. 2nd Tuesday monthly.
GUERNSEY—A. C. Smith, President, 1115 Clark Street, Cambridge 43725; Dayle O. Snyder, Secretary, 840 Wheeling Avenue, Cambridge 43725. 1st Tuesday monthly.
LICKING—Carl L. Petersilge, President, 104 Hudson Avenue, Newark 43055; Robert P. Raker, Secretary, 317 N. Granger Street, Granville 43023. 4th Tuesday monthly.
MORGAN—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, Box 199, Malta 43758.
MUSKINGUM—Paul A. Jones, President, 838 Market Street, Zanesville 43701; Myron Powelson, Secretary, 2825 Maple Avenue, Zanesville 43705. 2nd Tuesday monthly.
NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, 415 Main Street, Caldwell 43724. 1st Tuesday monthly.
PERRY—Charles B. McDougal, President, 319 High St., New Lexington 43764; Michael P. Clouse, Secretary, West Main St., Somerset 43783.
WASHINGTON—Mary L. Whitacre, President, Rt. 6, Marietta 45750; G. E. Huston, Secretary, 328 Fourth St., Marietta 45750. 2nd Wednesday monthly.

Ninth District

Councilor: George N. Spears, Ironton 45638
2213 S. 9th St.

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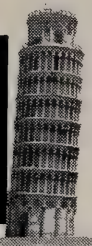
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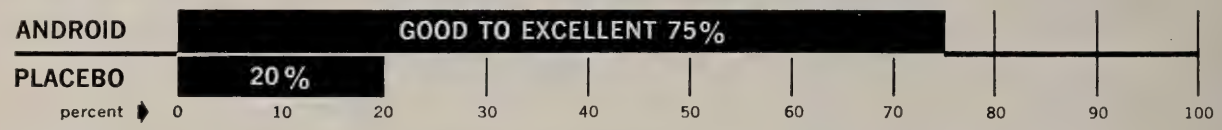
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Corporate Medical Laboratories: A Policy Statement of AAGP

Following is a statement of policy of the American Academy of General Practice as it appeared in the February, 1966, *AAGP Headquarters Bulletin:*

"Recently the Department of Medical Ethics of the American Medical Association forwarded correspondence from a physician asking for a statement of Academy policy concerning corporate medical laboratories. I answered the query by pointing out that no Academy policy exists in any form endorsing such laboratories.

"The Academy's position is in line with guidelines expressed by the AMA Judicial Council and a 1961 policy statement adopted by the AMA House of Delegates. That statement reads:

" 'The American Medical Association hereby declares that the proper conduct of laboratory analyses is a medical professional responsibility and all specimens and such analysis should be referred to laboratories supervised by fully qualified and licensed physicians.'

"The practice of pathology, both clinical and anatomical, is medical practice, of course. The AMA holds that operation of commercial laboratories by nonprofessional persons is against the public interest and degrades the practice of medicine.

"In 1965 the AMA Judicial Council issued an opinion regarding physician billing procedures for laboratory services. The council's ruling is:

" '1. The practice of pathology is an integral part of the practice of medicine.

" '2. All physicians should bill their patients directly, and

" '3. In exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services.'

"Because the guidelines are in the best interests of the public, the Academy does not permit laboratories that do not meet professional standards, or those whose practices would encourage members to contravene the policy of the Judicial Council, to exhibit at our Annual Scientific Assembly.

"In the interests of the public, I urge that you review the services of each applicant for space at your meetings to insure that every exhibitor offers a competent, professional service to the physician and the patients whom he serves.

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* * *

When physicians encounter an adverse drug reaction it is not uncommon for them to write to the distributor of the drug, possibly in the form of a complaint or as a request for information on similar experience. Reports are often transmitted through the detail man. No one knows as much about marketing experience with a drug as its distributor. — Ralph G. Smith, M. D., in *Journal of New Drugs,* (6:66), January-February 1966.

* * *

There is certainly room for generic drugs. But the effort to curb the branding of all drugs would be a disastrous body blow to the public. Countless research efforts, conducted at heavy expense both in money and manpower, come to nothing. Others produce valuable but specialized drugs, needed and used by but a few people who would die without them. The successful drugs in wide use must carry the costs. There is no other way. A trade name is the producer's guarantee of quality. And it rewards research and development which mean help to sufferers from the endless ailments which plague mankind. Why put a brake on medical progress — the road to ever better health. — Editorial in *St. Louis County Medical Society Bulletin,* (32:5) February 18, 1966.

* * *

When it comes to combating the tearful testimony of the various antivivisectionist groups we may be required to become just as emotional by using the testimony of grateful people who now live because of the contribution animals have made to medical knowledge. We must not be complacent. This is the year for the antivivisectionist — unless we combat emotions with truth. — Daniel B. Powell, M. D., in *Texas Medicine,* (62:27-28) February 1966.

* * *

". . . I would hate to be introducing digitalis as a new drug today. Anyone reading the toxicity and side effects would never use it in the present climate. However, digitalis has been with us long enough now that the toxicity and side effects have taken their proper place. They are there, to be sure, but not as prominently as the therapeutic effect. — Robert W. Ballard, M. D., in *Food Drug Cosmetic Law Journal,* (21:31-32), January 1966.

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REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

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John H. Mahan, St. Clairsville
Jerry E. Schmitthenner, Barnesville

Butler

Oscar A. Capo, Hamilton
George S. Hunt, Hamilton
C. Donald Stevens, Hamilton

Cuyahoga

R. Mario Abellera, Cleveland
Ralph J. Alfidi, Cleveland
Donald K. Anderson, Cleveland
Marshall W. Ashby, Cleveland
Alfredo A. Austria, Cleveland
Fillmore K. Bagatell, Cleveland
Margaret B. Cendo, Cleveland
Eva M. Dorre, Cleveland
Necdet Emir, Cleveland
John J. Eversman, Cleveland
Daryush Haghighi, Cleveland
Louis E. Hammond, Cleveland
Marinos D. Hionis, Cleveland
John J. Jane, Cleveland
Edgardo B. Katigbak, Cleveland
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David LaChance, Cleveland
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Philip E. Morgan, Cleveland
Robert Schwartz, Cleveland
Salvadore R. Torres, Cleveland
Philip A. Vlastaris, Cleveland
Theodore R. Warm, Cleveland

Franklin

Robert M. Curran, Columbus
Herbert G. Ewy, Columbus
Richard L. Klecker, Columbus
Donald L. Lewis, Columbus
John L. Melvin, Columbus

Franklin *(continued)*

William C. Segmiller, Jr., Columbus
John D. Trelford, Columbus
R. James Vaccarella, Columbus
Robert W. Vollmer, Columbus

Hamilton

Joseph D. Cionni, Cincinnati
Lawrence G. Kautz, Cincinnati
Floyd B. Main, Cincinnati
James H. Salmon, Cincinnati
Cecil H. Schapera, Cincinnati

Jackson

John W. Zimmerly, Jackson

Lucas

Charles D. Cobau, Toledo
John J. Culbertson, Sylvania
Justo M. Dominguez, Toledo
Pranas Neverauskas, Toledo
Jerry C. Rosenberg, Toledo
Charles E. Rowan, Toledo

Mahoning

Paulino R. Luna, Youngstown
Alfonso Corzo-Moody, Youngstown
Juan A. Ruiz-Oleaga, Youngstown

Marion

Albert N. May, Marion

Montgomery

John B. Bockoven, Dayton

Washington

Leopoldo Banuelos, Marietta
Millard C. Hanson, Marietta

Wood

Marjorie E. Conrad, Bowling Green

Dr. John P. Minton, Columbus, was guest speaker at the Tuscarawas County Cancer Crusade Kick-Off meeting in March. A clinical research fellow at Ohio State University working in the field of laser surgery, Dr. Minton has been awarded the 1965 James Ewing Society Resident Award, the 1965 USPHS Clinical Society Surgery Award, and the American Therapeutic Society's Oscar B. Hunter Memorial Award.

* * *

Dr. Albert Van Sickle, Batavia, health commissioner of Clermont County, is the new president of the Ohio Valley Health Commissioners' Association.

* * *

The Gold Headed Cane of the American Association of Pathologists and Bacteriologists was given to Dr. Harry Goldblatt, of Mount Sinai Hospital and Western Reserve University in recent ceremonies at the Hotel Statler Hilton in Cleveland.

* * *

Dr. Judson D. Wilson, Columbus orthopedic surgeon, was elected to the Board of Trustees of the Columbus Automobile Club. He filled the vacancy created by the death of Dr. C. C. Sherburne.

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

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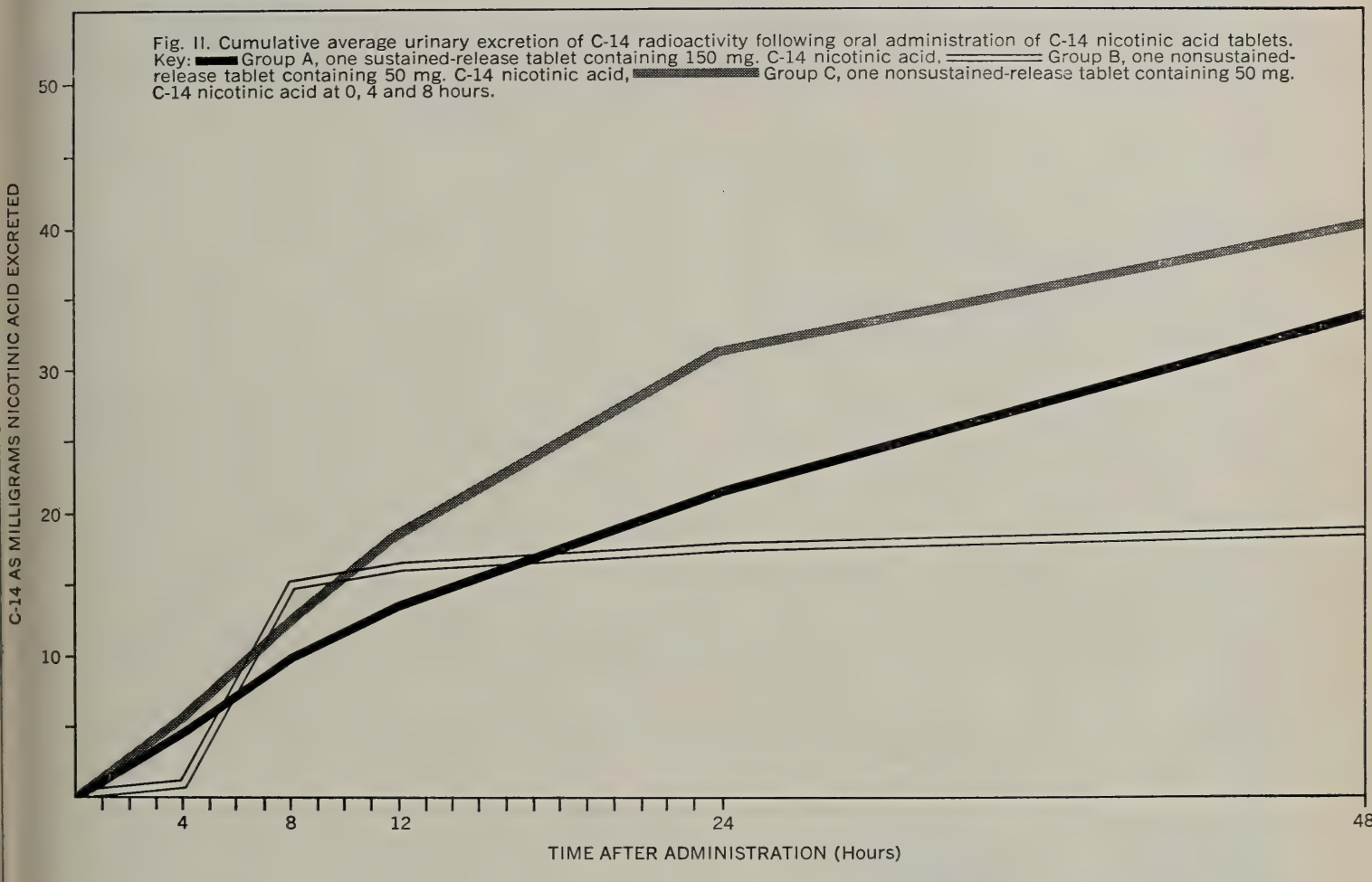
Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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M. D.'s in the News

Dr. Carl E. Wasmuth, Cleveland, spoke before the recent Ciba Foundation Symposium in London, England, where he appealed for legislation to give living persons the right to bequeath body organs for transplantation.

* * *

Dr. Robert M. Zollinger, Columbus, chief of surgery at Ohio State University College of Medicine, was principal speaker at a meeting of the Lancaster Rose Club. He is president of the American Rose Society.

* * *

The Southwestern Ohio Society of Family Physicians held its Spring Seminar on April 3 in the University of Cincinnati College of Medicine Auditorium. Subject of discussion was "Hematology."

* * *

Dr. Dwight L. Becker, Lima, spoke on "Medicare" before a meeting of St. Rita's Hospital Auxiliary.

* * *

Dr. George W. Petznick, Shaker Heights, spoke at a public meeting in the Heights Christian Church where he is an elder on the topic, "The Physician, the Clergy, and the Whole Man." He is a Past President of OSMA, is chairman of the OSMA Committee and member of the AMA Committee on Medicine and Religion.

* * *

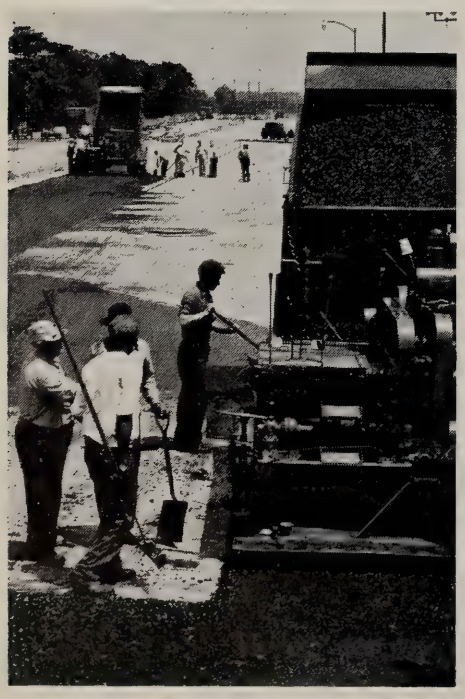
Dr. Martin P. Sayers, clinical associate professor in neurosurgery at Ohio State University, was speaker at a meeting of the Parents' Group of the Franklin County Society for Crippled Children at the Treatment Center in Columbus.

As an example of drug research expenditures which are unprofitable to a company, American Cyanamid Company of Pearl River, N. Y., invested about $37 million in drug research on live virus, polio vaccines, cancer, tuberculosis, heart disease and other maladies. No commercial products have resulted from this research and expenditure.

Included among the more than 40 reports of progress in radiology made to the convention of the American Roentgen Ray Society in Washington, D. C., was a paper by Drs. Hymer L. Freidell, Earle C. Gregg, and Abbas M. Rejali, all of Cleveland. The topic was "Radioisotope Scanning with a System for Total Information Storage and Controlled Retrieval."

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References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.

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OSMJ Scientific Section

VOL. 62 MAY, 1966 NO. 5

Adenomatous Polyps of the Colon

ABDUL F. NAJI, M.D., FAYIZ A. SALWAN, M.D.,
and ROBERT R. BARTUNEK, M.D.

THE view expressed by Helwig[1] and Coffey[2] that the majority of carcinomas of the large intestine arise from pre-existing adenomas, is not shared by recent authors. It is more likely that most invasive carcinomas are malignant tumors from the onset. Spratt, Ackerman and associates[3,4] disagree with the theory claiming that adenomatous polyps may degenerate into infiltrating metastasizing carcinomas of the colon. The views of these authors do not express an alarming reaction concerning adenomatous polyps.

Fitts and associates[5] believe that in some instances frankly invading and metastasizing cancer appears to develop from adenoma and that all degrees of dysplasia, from minor atypical changes to invasive metastasizing carcinomas, can be found in any large group of adenomatous polyps. They urge that all polypoid lesions of the colon be removed and studied microscopically unless the operative risk is prohibitive.

Turell,[6] in 1959, mentioned his previous observations of adenomatous tissue in adenocarcinomas in 16 out of 150 consecutive rectocolic surgical specimens. In 1962 he[7] stated that there is mounting evidence against the theory that solitary adenomas transform into invasive metastasizing fatal cancers. He advised a practical 'middle-of-the-road' position toward polyps, especially regarding treatment. There is almost unanimous agreement that the incidence of malignancy in colonic polyps increases to a significant degree in the larger lesions. In Ackerman's series, lesions between 1.25 and 1.97 cm. in diameter showed a 12 per cent occurrence of carcinoma. The incidence was 100 per cent in all lesions over 3 cm. in diameter.

During a two-year period (1962 and 1963) each colonic biopsy has been examined independently by three pathologists at St. Alexis Hospital. In several cases there was marked difference of opinion as to the benignancy or malignancy of a particular specimen, and occasionally it was difficult to determine whether the biopsies represented fragments of a polyp or of a colonic carcinoma. Usually the correct diagnosis was not ascertained until serial section studies, further biopsies, or more elaborate surgical procedures were done.

This paper includes our findings in 67 cases of colonic polyps. These represent surgical specimens,

Submitted July 30, 1965.

The Authors

- **Dr. Naji, Cleveland, is Director, Department of Pathology, St. Alexis Hospital; Instructor in Pathology, Metropolitan General Hospital, and Western Reserve University School of Medicine.**
- **Dr. Salwan, Cleveland, is Associate Director of Medical Education in Surgery, St. Alexis Hospital; Fellowship of the American Cancer Society, Cuyahoga Unit.**
- **Dr. Bartunek, Cleveland, is Director, Gastroenterology, St. Alexis Hospital, and Director, Gastroenterology, St. Vincent Charity Hospital; Assistant Clinical Professor of Medicine, Western Reserve University School of Medicine.**

most of which were encountered within the period of our study. Cases of polyps in children and villous adenomas have not been included in this study. Large colonic biopsies and all polypoid lesions received in the Pathology Department were fixed in 4 per cent formaldehyde for 24 hours. They were then cut and embedded entirely (Fig. 1). Small fragments



FIG. 1. *Gross specimen. Bisected polypoid lesion of colon after twenty-four fixation in formalin.*

were fixed for six hours and processed the same day. Serial section studies were made on lesions showing foci of dysplasia. The stains used were mainly hematoxylin and eosin.

The Anatomy of a Polyp

The body, the main portion of the polyp, consists of a central stromal mass of vascular fibrous and smooth muscle tissue (Fig. 2). This sends out numerous peripheral extensions of the same kind of tissue, around which are found branching and anastomosing glands separated by a variable amount of supporting interglandular stroma. The glands are lined by tall columnar cells. In most polyps a lobulated pattern is noticeable on gross and microscopic examination. The stroma may contain variable amounts of inflammatory cellular infiltration consisting mainly of polymorphonuclear leukocytes and lymphocytes. Foci of old or recent hemorrhage may also be present within the stroma.

The glands of a polyp are generally larger and show more variation in size and shape than those found in normal colonic mucosa. Their cells are two or three times taller. The differentiation between the glands of a polyp and those of colonic mucosa is simple even when only a few glands are available for examination. A striking feature of the glands of a polyp is the marked nuclear layering or stratification. There are five or more layers of nuclei occupying the basal half of the cells. The basal and the luminal margins of the cells are usually sharply demarcated. The intercellular boundaries are less

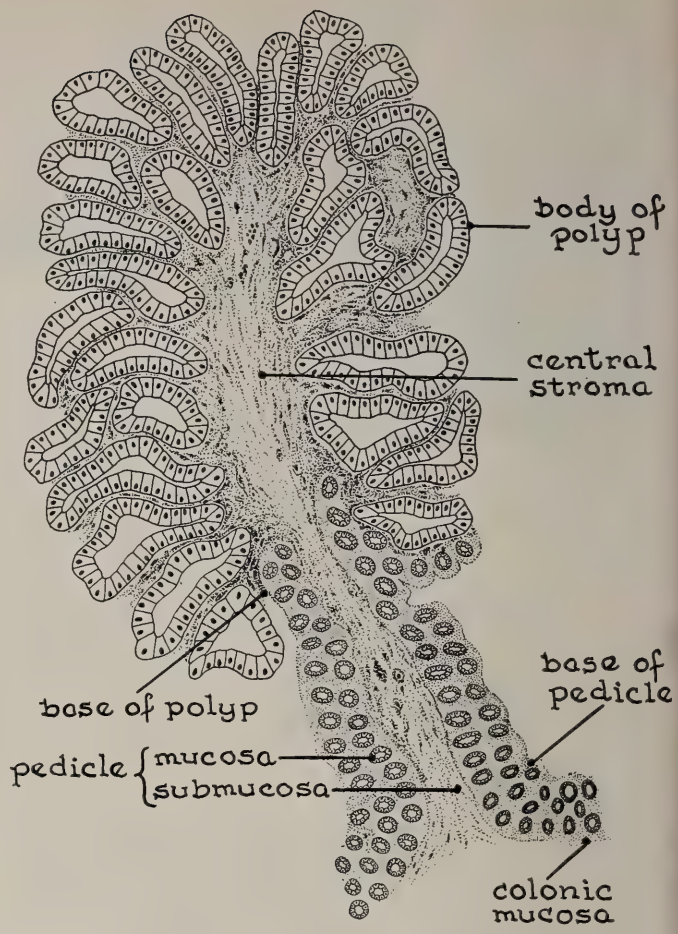


FIG. 2. *Diagram illustrating the anatomy of a polyp.*

distinct, especially if the cells do not show mucin vacuoles. Mucin within cells or within glands is present in variable amounts.

An adenomatous polyp may be sessile or it may be pedunculated. The pedicle, which is not a true part of the polyp, is formed of a cylindroid extension of normal colonic mucosa, with or without submucosa and muscularis mucosa. It usually measures from 1 to 3 cm. in length and from 0.2 to 1.0 cm. in diameter. The pedicle is formed as a result of the peristaltic pressure on the body of the polyp. The central stroma of the pedicle is continuous with that of the body of the polyp. On the opposite end the mucosa and stroma of the pedicle join the corresponding structures of the colon. The main muscular layers of the colon are usually not involved in the formation of the pedicle.

Etiology of Colonic Polyps

As is the case in most benign and malignant neoplasms, the etiology of colonic polyps remains unknown. It is generally agreed that true adenomatous polyps are neoplasms which result from focal mucosal cell hyperplasia. It is quite possible that the same stimuli responsible for the production of colonic carcinoma are also responsible for the development of colonic polyps. Adenomatous polyps occur with greatest frequency in the age groups in which the

incidence of colonic carcinoma is also high. The frequent occurrence of more than one polyp in a surgical or autopsy specimen of colon may indicate that these polyps arise as the result of multifocal stimuli or as the result of a diffuse systemic stimulus leading to foci of abnormal cell hyperplasia. It is conceivable that whenever there is a polyp in the colon, other cells within the colon have the potentiality of producing more polyps.

Dunphy and associates[8] reported their observation of regression of congenital polyposis of the colon following subtotal colectomy and ileocolostomy. They also acknowledged Turnbull's similar observation. The authors speculate that a factor leading to polyposis or carcinogenesis produced or activated by the colonic mucosa may be in existence.

Studies of desoxyribose nucleic acids (DNA) of nuclei of colonic mucosa, colonic polyps and carcinomas by Cole and McKalen[9] revealed that the majority of nuclei of adenomatous polyps had similar DNA values to those of normal colonic mucosa, i.e., diploid. However, in three out of five cases of polyps, polypoid DNA values were present in many cells. Increased DNA content was noted in nuclei of cells obtained from adenomatous polyps as well as carcinomas. Leuchtenberger and Lieb[10] reported the presence of cytoplasmic inclusions in colonic polyps.

The role of heredity in familial polyposis is well known. The colonic mucosa of persons having this genetic factor has a tendency to produce patches of hyperplasia. It is likely that these patches of hyperplastic mucosa are more prone to produce carcinomas than ordinary colonic mucosa. Dukes[11] believes that in these individuals cancer is a secondary and in a sense an accidental phenomenon following an inherited precancerous lesion.



FIG. 3-a. *Photomicrograph. Polypoid lesion of colon. The gross appearance was suggestive of pedunculated adenomatous polyp. The microscopic examination revealed carcinoma.*

Criteria of Malignancy in Adenomatous Polyps

It is impossible to determine with certainty the benign or malignant nature of a polypoid colonic lesion on the basis of gross examination alone. It has been observed that most small lesions are benign, whereas larger lesions (over 3 cm. in diameter) frequently prove to be malignant. However, exceptions to this rule are quite common. The polypoid configuration and the presence of a pedicle likewise do not necessarily indicate benignancy (Figs. 3a and 3b). The purplish, coarse and slightly firm characteristics of a lesion may occasionally arouse suspicion of malignancy. However, strangulation of a benign polyp may produce this purplish appearance. A firm consistency localized in one part of the polyp may indicate focal dysplasia. A magnifying glass may reveal distortion of the lobular pattern on the cut surface of a polyp in dysplastic areas.

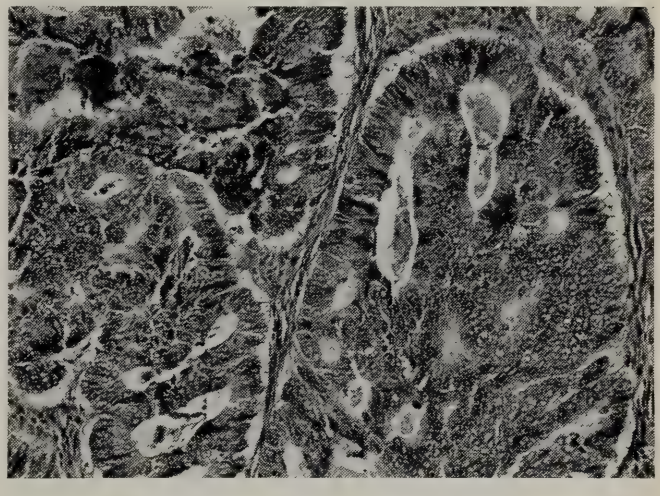


FIG. 3-b. *Photomicrograph. Same case as in Fig. 3-a. Partially differentiated adenocarcinoma.*

We have found that frozen sections are of limited help in the diagnosis and management of colonic polyps. They may even interfere with a thorough study of these lesions by routine permanent sections.

Microscopically even minor deviations from the ordinary benign glandular pattern of a polyp are easily recognized. All grades of dysplasia may be seen, ranging from slight atypism to obvious carcinoma (Figs. 4a, 4b and 4c). The glands in a malignant area may show loss of polarity and lack of uniformity in size and shape. They may appear crowded within the stroma, which tends to be more dense and eosinophilic. The individual cells are not consistent in size in benign or malignant polyps, although in either case they are markedly larger than those of normal colonic mucosa.

Multinucleation and nuclear layering or stratification is common in both benign and malignant areas; however, in the benign foci the nuclei tend to be located



FIG. 4-a. *Photomicrograph. Adenomatous polyp of colon. Arrow points to a focus of marked dysplasia.*



FIG. 4-b. *Photomicrograph. Same case as in Fig. 4-a. Benign adenomatous tissue comprising most of the lesion.*

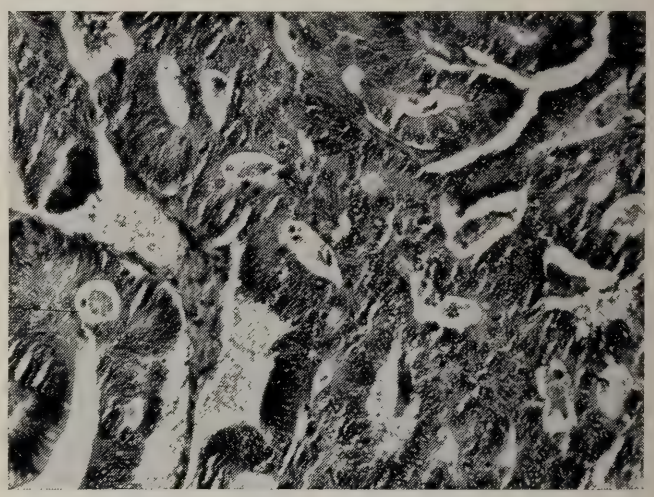


FIG. 4-c. *Photomicrograph. Same case as in 4-a. and 4-b showing an area of marked dysplasia.*

in the basal half of the cell. The apical portion of the cell is either acidophilic or filled with mucin. In the malignant areas the nuclei may be central. In view of the macronucleosis and hyperchromasia of a malignant cell, the nuclear component in a malignant area appears in greater abundance than in a benign area. Malignant cells also exhibit prominent nucleoli. The cytoplasm of a malignant cell is usually less acidophilic than that of a benign cell. The adjacent malignant cells may loose their intercellular boundaries and a syncytial nuclear arrangement is not uncommon. Mitotic figures and abnormal mitoses are more frequent in malignant areas. The presence of cords and sheets of malignant cells, with or without discernible lumens within dense stroma makes a diagnosis of malignancy in a polypoid lesion relatively simple.

Dysplastic areas may be noted in the peripheral zones or within the glandular mass of the body of the polyp. In such cases the changes may be entirely intra-epithelial. Many authors decline to call such foci carcinomas regardless of the extent of dysplasia. They limit the diagnosis of carcinoma to lesions which show evidence of invasion. We believe that if the changes in such isolated intra-epithelial foci are severe enough to suggest carcinoma on a morphological basis, they should then be considered intra-epithelial carcinomas (Fig. 5).

Invasion in a dysplastic adenomatous polyp of the colon may involve the central stromal mass or the pedicle. When invasion is limited to the central stroma near its junction with the glandular portion one should rule out the possibility of false invasion in a benign polyp. In such cases the general morphology of the entire polyp and the extent of cellular dysplasia will be the deciding factor in the diagnosis. Invasion of the stroma of the pedicle beyond the base of the polyp should be considered submucosal invasion.

Clinical Material

Sixty-seven cases of adenomatous polyps of the colon were studied. Forty-four patients were male and 23 were female. The youngest patient was 32 years old and the oldest was 86. In patients in the



FIG. 5. *Photomicrograph. Adenomatous polyp. Arrow points to a focus of intra-epithelial carcinoma.*

sixth, seventh and eighth decades, the incidence of polyps, with or without associated carcinoma, was the highest. In 47 patients we found 58 polyps, some with dysplastic changes. The remaining 20 patients had 22 polyps associated with independent carcinoma elsewhere in the colon. Forty-three of the polyps were located within 25 cm. of the anal verge. In five cases in our series the polyps were found on routine examination and the patients had no previous symptoms related to their presence. The most frequent symptom related to colonic polyps was lower gastrointestinal bleeding. This was present in 32 of the 47 patients who had polyps without independent carcinoma. In four additional cases blood-streaked mucus was present. Next in frequency was the complaint of vague abdominal pain or intermittent cramps. This was mentioned on 15 occasions. Other infrequent symptoms were constipation, changes in bowel habit, anal discomfort, pruritis and prolapse of a rectal mass.

The diagnosis was made by digital or proctoscopic examination when the polyp was located within the rectum. Sigmoidoscopy aided in the diagnosis of other polyps which were beyond the reach of the finger or proctoscope. Roentgenological examination of the colon was used to demonstrate lesions above the level of the rectosigmoid. On several occasions we encountered lesions which were observed only through air contrast studies following expulsion of barium.

Polyps which were associated with carcinomas were treated as part of the major disease. In most of these cases the polyps were found following colonic resection for carcinoma, hence their presence did not affect the type of treatment employed. Thirty-one cases of polyps not associated with carcinoma were treated by simple resection through the pedicle with cauterization of the pedicle base. These were approached from below through a proctoscope or sigmoidoscope. In nine cases transabdominal colotomy was necessary and the polyps were removed at the base of the pedicle. In seven cases the segment of the colon which included the polyp was resected.

Pathological Findings

In accordance with the presence or absence of dysplastic changes in the polyps, we classified our cases as follows:

1. Benign adenomatous polyps: *17 cases.*
2. Adenomatous polyp with slight focal epithelial dysplasia: *16 cases.*
3. Adenomatous polyp with marked focal dysplasia without stromal invasion: *6 cases.*
4. Adenomatous polyp with focal carcinomatous changes: *1 case.*
5. Adenomatous polyp with focal carcinomatous changes and stromal invasion: *5 cases.*
6. Carcinomatous polyp: *2 cases.*

Type 1 represented the usual adenomatous polyp with no evidence of dysplasia. In Type 2 the changes were limited to one or more areas where the glands were somewhat different from those of the rest of the polyp and were formed of cells possessing slightly hyperchromatic nuclei. Mitoses were rare. In Type 3 these changes were more striking and impressive, but not enough so to make a diagnosis of carcinoma. Type 4 was designated to polyps with intra-epithelial carcinoma. In Type 5 focal carcinomas were present with evidence of stromal invasion. A carcinomatous polyp (Type 6) is a lesion in which the polypoid configuration is retained but the entire body of the polyp is formed of carcinomatous tissue. It is distinguishable from polypoid carcinoma in that the latter has a wide base and does not have the configuration of a polyp. It may possess more than one marginal or surface polypoid projection of carcinomatous tissue.

In the remaining 20 cases independent carcinoma was present in association with the polyp. Ten of these showed dysplasia in the polyp with stromal invasion similar to the independent carcinoma. In the remaining 10 cases no dysplasia was present in the polyp.

In one case the patient had multiple filiform polyps of the terminal ileum and seven benign adenomatous polyps of the colon. Five of the latter were attached at their bases to a large ulcerating carcinoma of the ascending colon (Fig. 6).

Summary and Conclusions

The controversy regarding adenomatous polyps of the colon is briefly reviewed. There is still some disagreement as to the exact nature and behavior of these lesions. The anatomy of colonic polyps, their etiology and criteria of malignancy are discussed. The clinical and pathological findings in 67 cases of col-

onic adenomatous polyps are presented. In 20 cases an associated independent carcinoma was present elsewhere in the colon.

The management of a polypoid colonic lesion should be a shared responsibility of the surgeon and the pathologist. When detected, a polypoid lesion of the colon should be removed unless the surgical risk is prohibitive. Total polypectomy is highly preferred to a fractional removal. All the material should be studied microscopically. Although the majority of adenomatous polyps of the colon are benign, a significant number prove to be malignant. In our series approximately 12 per cent of the polyps showed carcinomatous changes. In an additional 10 per cent marked focal dysplasia was present. Thorough surgical treatment of polypoid colonic lesions should result in the cure of many early colonic carcinomas. The presence of all grades of dysplasia in a given number of polypoid lesions may point to a common etiology for both polyps and carcinomas.



FIG. 6. *Photomicrograph. Base of pedicle of adenomatous polyp implanted in area of carcinoma.*

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DISPENSING THE SAMPLE. — The samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item.

It might be best to tell the patient: "This is a sample of a new (or a good old) medicine that has had some fine results. If it is as favorable as I expect it to be, take the prescription to your neighborhood drug store so you can get more of this medicine. If you are disappointed in the results, call me."

This simple procedure will prevent the embarrassment of an otherwise satisfied patient trying to get the drug without a prescription. It will lift the medication into the dignified "prescription" class rather than make it look like a casual free sample. It indicates that the doctor is not going out on a limb, calling it a wonder drug. And it acts as an automatic (if not entirely scientific) check on the effectiveness and safety of a new drug. — EDITORIAL: *The Journal of the Medical Society of New Jersey,* Vol. 62 — Number 12 — December, 1965.

Aging and the Skin

CAPT. LAWRENCE B. MEYERSON,* M. C.

"Little of all we value here,
Wakes on the morn of its hundredth year,
Without both feeling and looking queer,
In fact, there's nothing that keeps its youth,
So far as I know but a tree and truth.
(This is a moral that runs at large,
Take it — You're welcome — No extra charge.)"
— O. W. Holmes: *The Wonderful One Hoss Shay*

* * *

"What is it to grow old?
Is it to lose the glory of the form,
The lustre of the eye?
Is it for Beauty to forego her wreath?
Yes; but not this alone."
— Matthew Arnold: *Growing Old*

* * *

THE phenomenon of aging is familiar to all, yet through the years the exact explanations for the changes seen have been difficult to uncover. Even the definition of aging has been a controversial subject. Strehler, and his associates[1] define aging as "the progressive loss of functional capacity of an organism after it has reached reproductive maturity" and "a progressive decline in vigor which is registered in any one of many ways, most generally by an increasing probability of death." Thus aging tissue, including the skin, provides a favorable environment for some diseases such as cancer, while withstanding the stress of other diseases less than does younger tissue.

Many theories have been proposed to explain the general phenomenon of aging, and I wish to discuss the three best known theories briefly before going into the specific subject of skin aging.

One theory postulates that an accumulation of deleterious products of metabolism causes aging. It is known that products such as collagen accumulate in certain tissues, as in the skin, and give these organs the appearance of older organs. However, accumulation is marked in some tissues and practically absent in others. Furthermore, as Curtis[2] points out, organs such as skeletal muscle which show little, if any, accumulation of products, have marked aging changes, and decreased muscular ability is one of the first signs of aging. Thus, even though this theory cannot be completely discounted it seems more likely that these products accumulate as a result of aging rather than as its cause.

A second theory has been termed the "wear and tear" theory. It holds that every stress or disease which an organ is exposed to takes its toll, and the organ finally wears out. That is, when a disease or other trauma causes damage, though the victim appears to recover completely, some residual damage remains which rarely, if ever, heals. This theory is very attractive because it seems to fit very nicely with the familiar pattern of aging in inanimate objects,[3] such as a river wearing away the rocks on its bank. However, recent experiments cast doubt on this theory. If a series of animals is given a dose of nitrogen mustard or typhoid toxin so that one half of the animals die, those which survive have no shortening of their life span.[2] Also, if small injections of tetanus toxoid, typhoid toxin, nitrogen mustard, or turpentine are given at frequent intervals just short of causing death, no accelerated aging of the animals was found.[2] The only agent found to accelerate aging is radiation, which leads us to another theory.

A third theory of aging is that of somatic mutation. This theory postulates that somatic cells, through a series of natural and environmentally induced mutations, gradually accumulate harmful genes which cause an increasingly larger number of cells, and therefore the organ, to function poorly. General support for this is the evidence that ionizing radiation produces both chromosome aberrations and a nonspecific reduction in the life span of experimental animals.[2] It is also known that older animals show higher percentages of cell abnormalities than younger animals of the same strain, and strains with a normally shorter life span have cells with a greater percentage of nuclear abnormalities than do strains with longer life spans.[2] A recent study by Anderson[4] on the survivors of the Hiroshima atomic explosion tends to confirm the fact that exposure to radiation accelerates aging in humans. In this paper he proposes a possible relationship between aging, radiation, and decreased longevity (See Fig. 1). This theory will be discussed more thoroughly in relation to the aging skin.

The Aging Skin

The skin is a fascinating organ — the largest and most versatile in the body, and man is extremely de-

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pendent on the properties of his skin. It provides an effective shield against many forms of chemical or physical attacks. It helps repel the strong ultraviolet rays of the sun. It keeps out microorganisms and foreign material, as well as holding in the body's fluids. It is the principal participant in cooling the body when it is hot, and preventing heat loss when it is cold. It is important in the regulation of blood pressure and blood flow. It provides our nervous system with information from our environment — pain, touch, and temperature. It is the means by which we identify others, as well as a key to our individuality. And last, but certainly not least, it is the principal organ of sexual attraction. In general, all of these functions are noticeably altered as the skin ages.

The skin is made up of two basic components: The epidermis, the outer surface layer, which is composed of stratified squamous epithelium whose top layer of dead cells, the horny layer, serves as the principal shield of the body. Its lower layer contains the pigment melanin which is produced by melanocytes scattered deep in the epidermis. The melanocytes are spider-shaped with long processes that inject granules of melanin into the surrounding epidermal cells. This melanin forms a protective covering for the cell nuclei by absorbing the ultraviolet rays of the sun. All men, regardless of their race, have approximately the same number of melanocytes in their skin, the difference being that those in the darker races manufacture more pigment than those in the lighter races.[5] This has evolved in the tropical peoples of the world as a protective mechanism with high survival value. Both the melanin and the horny layers have importance in the skin's aging process, as will be discussed later.

The second layer of the skin, the dermis, which underlies the epidermis, is composed chiefly of thick fibrous tissue and contains the nervous and vascular supply to the skin. The collagen fibers and dermal ridges are the parts of this layer which are important in aging.

Man's skin follows an interesting life cycle.

> In infancy and early childhood it is dry, soft, velvety, clear, and apparently almost hairless. Because it is so free of blemishes and presumably because it suggests the clear, soft skin of a sexually attractive young woman, baby skin has come to be regarded as the epitome of skin beauty.[5]

During adolescence the hair follicles enlarge and a more active growth of hair begins. The sebaceous and sweat glands go from a near dormant state to full activity. "Physiologically speaking the skin arrives at full bloom with puberty."[5] The skin, after this, runs a downhill course, being abused by both natural and man-made hazards, such as sunlight, wind, soaps, powders, chemicals, etc., to arrive decades later as the dry, wrinkled flaccid skin of old age, "a tired organ — a relic of what it was in its youth."[5]

The skin changes so notably as one grows older, that its appearance is the standard by which a person's age is estimated. This is shown by the vast sums of money spent on cosmetics in the hope of masking these changes.

In considering the factors which cause cutaneous aging, one must distinguish those changes produced in exposed areas of the skin by weathering and sun-

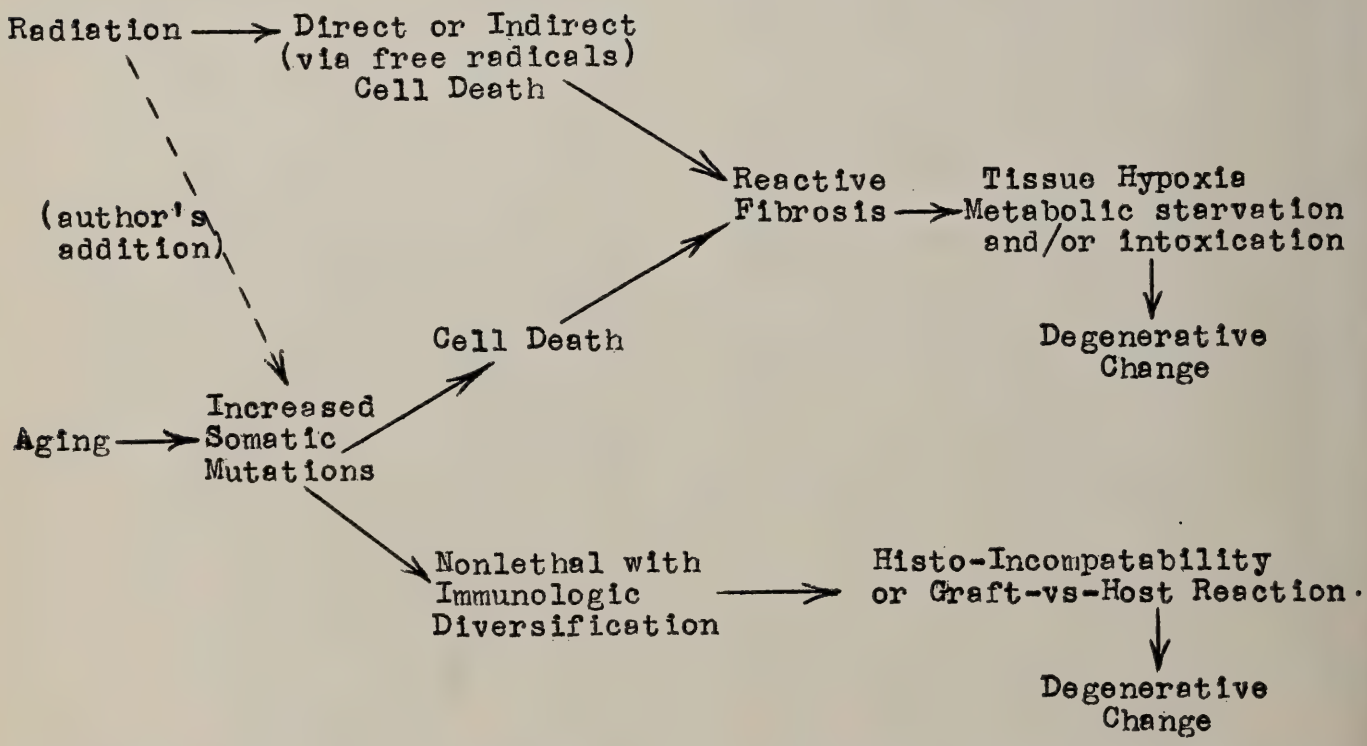


FIG. 1. *This chart illustrates a proposed relationship between aging, radiation, and decreased longevity.*[4]

light from the senile changes seen in areas of the skin normally covered by clothes.

Actinic Damage

Outdoor workers have skin that appears older than those who work indoors and they also have an increased incidence of skin cancers. Often in white adults a striking difference may be noted between areas of the skin which are exposed to the sun and those that are not. In contrast to this, elderly Negroes may have skin that appears very young because of its natural protection by the high melanin content.

Changes seen in actinically damaged skin include laxity and wrinkling, a yellowish color, and a dry coarse, leathery appearance. There usually is telangiectasia, and pigmentary changes such as senile freckles or speckled areas of depigmentation may be found. Also, premalignant keratoses or malignant neoplasms may develop in the skin.

These changes, rather than depending on the actual passage of time, probably depend on (1) exposure to wind and weather, (2) the amount of ultraviolet radiation in the range between 2,800 and 3,100 angstrom wave lengths which have struck the skin, and (3) genetic factors that determine the skin's resistance to this exposure.[6]

Physiologic responses to ultraviolet light include thickening of the stratum corneum or horny layer plus hyperplasia and an increased production of melanin.[6] These are maintained only with regular absorption of ultraviolet light by cells below the horny layer. Most experts agree that the principal layer which absorbs ultraviolet light is the stratum corneum and that past this layer the only barrier to it reaching the dermis is melanin. Persons with fair skin tend to be deficient in both these factors, as well as in their ability to respond to solar exposure by increasing their defenses. This is why the lighter races suffer more actinic damage than the dark races.

Histopathologically, the degenerative changes observed in the exposed skin are primarily alterations in the connective tissue in the dermal papillae.[7] Curling and fragmentation of elastic fibrils in the papillary zone is considered to be the earliest sign of actinic damage. This condition is often called "senile elastosis," but it is actually a combination of elastin and collagen degeneration and is not related to senility. Therefore, many authors suggest a more proper term would be "solar elastosis."

Knox[7] feels that, on the basis of his study and works of others, the onset of collagen degeneration is in all probability independent of age, and is only dependent on the cumulative effects of ultraviolet light exposure. He further states that "the visible cutaneous changes usually interpreted as aging are apparently due largely, if not entirely, to sunlight."

However, even though it is well recognized that much of the aging of the skin can be avoided in white-skinned persons by decreasing solar exposure, we must realize that *other* factors are also involved. Otherwise we may develop a concept mentioned by Daniels[8] of

> plump, smooth-skinned, seventy-five year old "bunny girls" spending their entire nocturnal lives as attractions in night clubs and scurrying into darkrooms or coal mines before sunrise, thus maintaining their smoothness and roundness, but making them very pale.

Aging in Nonexposed Skin

The etiology of aging in *nonexposed* skin remains to be explained. It is not known to what degree cutaneous aging is intrinsically determined by environmental and genetic factors, or to what degree it is secondary to endocrine, vascular, or senile changes in the rest of the individual.

The surface of unexposed senile skin is more finely wrinkled, dry, and shiny than younger skin. It also lacks the elasticity and turgor of normal skin, which tends to result in redundancy and folding.

The effects of aging on various parts of the skin and its appendages are best considered separately.

Involution of sebaceous glands, with consequent decreased sebum production, occurs postmenopausally in women and much later — in about the 70's, in men. This apparently is due largely to loss of endocrine factors that stimulate these glands — progesterone in women and androgens in men.[9] An interesting fact is that in the aged woman sebaceous excretion can be increased to normal levels by systemic administration of progesterone.[10] Therefore, at least in this function, the changes of aging can be reversed by exogenous factors.

Sweat secretion decreases gradually with age, especially after the age of 70.[6] Apocrine secretion decreases earlier and more sharply than eccrine secretion. Senile sweat glands, when artificially stimulated, react more slowly and are easily exhausted. The sodium content of senile sweat, especially in men, may be very low or absent.

The keratinization process also undergoes certain changes with age. The rate of keratinization decreases as one gets older. The rate of keratinization is probably an indication of mitotic rates in the cells which synthesize keratin, the underlying epidermal cells. Thuringer and Katzberg[11] through their experiments found the number of mitoses in the outer third of the epidermis to decrease dramatically with age while the number in basal areas actually increased with age up to 70 years. (Perhaps this is significant in the etiology of basal cell carcinomas.)

In senescence, nail growth rates decrease strikingly to about equal levels in both sexes, in contrast to the normally more rapid nail growth in men than in women.[6] The nail also may become brittle or dystrophic, and the toenails are often thickened.

Graying hair, although associated with senescence, is very dependent on genetic factors in determining its onset. It is now thought to be due to a decrease or loss of melanocytes from the germinative epithe-

lium of the affected hair follicles.[12] There is also a general reduction in the quantity of body and scalp hair with aging. Axillary hair is commonly lost and this occurs earlier and is more pronounced in women. Pubic hair also decreases in old age, but less notably.

Small blood vessel fragility is found in senile skin, and appears to be due to degeneration of the connective tissue surrounding the vessels.[6] Senile purpura is the primary manifestation of this and is usually seen on the back of the hands and forearms.

"Senile skin can be viewed physiologically as having generally reduced homeostatic faculties and greater vulnerability to injury."[6]

Discussion

In general, aging seems to modify the dermis and the cutaneous appendages much more than it modifies the epidermis and its functions. In fact, the superficial atrophic appearance and fine wrinkling of senile skin is caused more by flattening and atrophy of dermal papillae than by reduced epidermal thickness or reproductive ability.[7]

Thus, the present knowledge of the aging skin seems to support the theory of mutation mentioned earlier as a possible explanation of the mechanism of aging. By this concept, actively mitotic organs would be able to negate the effects of mutations which weaken its cells by proliferation of more vigorous cells. Organs with low mitotic rates, however, could not do this and would become composed of greater and greater numbers of less vigorous cells, and would consequently be the organs which would show aging.[2] Thus, cell populations with continual turnover, such as the bone marrow and epidermis, effectively replace defective mutants with healthier cells, while muscle, connective tissue (including the dermis), and brain cells, which are not replaced, gradually accumulate mutant cells and have progressive cellular dysfunction and individual cell mortality. This possibly explains why aging affects the dermis, composed of static connective tissue, more than the rapidly proliferating epidermis.

Despite the many theories which attempt to explain the aging of the skin, many feel the way Stoughton[10] does:

> let us say that we all know that an ancient person has paper thin, shrivelled, cracked, lifeless, spotted, yellowish, hairless, hanging skin — but we don't really know how it got that way.

> *"Another example can be given in the field of medicine in regard to the prolongation of human life, for which the medical art has nothing to offer except the regimen of health. But a far longer extension of life is possible.*
>
> *"Therefore in regard to this we must strive, that the wonderful and ineffable utility and splendor of experimental science may appear and the pathway may be opened to the greatest secret of secrets."*
>
> — Roger Bacon: *Opus Majus*

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CHEMICAL AND BIOLOGIC WEAPONS. — There has been remarkably little public debate, particularly among physicians, on the advisability of developing, stockpiling and using chemical and biologic weapons. Some of these issues, admittedly, are complex, controversial and uncomfortable. The physician, however, has a specialized knowledge about chemical and biologic agents. No nation could develop or protect against this kind of warfare without aid from its doctors. In addition to his particular competence, the physician must be concerned with chemical and biologic weaponry because of his fixed commitment to the health of individuals, singly and collectively. He must therefore be actively concerned with the medical consequences of chemical and biologic warfare. — Victor W. Sidel, M. D., and Robert M. Goldwyn, M. D., Boston: *The New England Journal of Medicine,* 274:21-27, January 6, 1966.

Frank Vectorcardiograms Of Normal Adults

ROBERT T. MURNANE, M. D., LOUIS B. SKIMMING, M. D.,
GALEN H. DAVIS, M. D., and JAMES R. SNYDER, M. D.

SEVERAL investigators have reported on the value of oscilloscopic spatial vectorcardiography in diagnosis as an adjunct to routine scalar electrocardiography. This method of studying the cardiac electromotive forces is attracting increasing attention.

Schellong[1] 1937 and Johnston[2] 1938 demonstrated the advantages of the oscilloscope to display vectorially in loop form the temporal and spatial characteristics of cardiac electromotive forces. Widespread acceptance of the technique has been delayed in part because agreement was not reached regarding the leading system to be used and because of the limitations of available electronic recording equipment.

Coincident with engineering advancements in the instrumentation, several investigators[3-6] independently proposed leading systems with variable practical and mathematical limitations. Many laboratories have recently adopted the corrected orthogonal network proposed by Frank.[7] His system permits easy clinical application and gives results very close to those obtained with more complex lead systems.[8]

From 1960 through 1964, 2000 adult inpatients with manifest or suspected myocardial infarction were studied at the bedside with the Frank system of spatial loop vectorcardiography in this institution.

This paper presents data recorded with the Frank system in a group of normal adult subjects. The vector intervals chosen for measurement were those found to be useful for comparison with records obtained in subjects with myocardial destructive lesions. A comparison of these results with the limited number of reports[9-12] dealing with the normal Frank vectorcardiogram is presented. This was done as a test of the practical reproducibility of this method.

A report[13] on 100 normal children has appeared which presents angular and magnitude data of *initial* and *terminal* timed intervals of the QRS loop studied with the Frank system. A similarly comprehensive report dealing with normal adults has not appeared.

In this study the Frank vectorcardiogram was applied to a group of normal adults in broad age range providing data on rotational direction, angular, and magnitude measurements for clinically important vector intervals of the P, QRS, and T loops. Angular and magnitude measurements of successive, timed, *initial,* and *terminal* QRS vectors were determined.

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- **Dr. Snyder, Suitland, Maryland, former Research Fellow in Cardiology, The Ohio State University Hospital, presently is a Fellow in Cardiology, Georgetown University, Washington, D. C.**

Materials and Methods

The 124 adult subjects of this study were professional and lay personnel of the Mount Carmel Hospital in an age range of 20 to 69 years (Table 1).

TABLE 1. *Age and Sex Distribution of Subjects Studied.*

Age Group (Years)	Female	Male	No. of Subjects
20 - 29	19	17	36
30 - 39	15	15	30
40 - 49	8	14	22
50 - 59	8	10	18
60 - 69	11	7	18
Totals	61	63	124

None had a history of heart, lung, or kidney disease. Each was chosen on the basis of normal physical examination, chest x-ray, and 12-lead electrocardiogram.

The Frank leading system was used to record the spatial loop vectorcardiograms projected onto three mutually perpendicular planes (Fig. 1). The projection onto the sagittal plane was recorded as viewed from the subjects left.[14] The fifth intercostal space

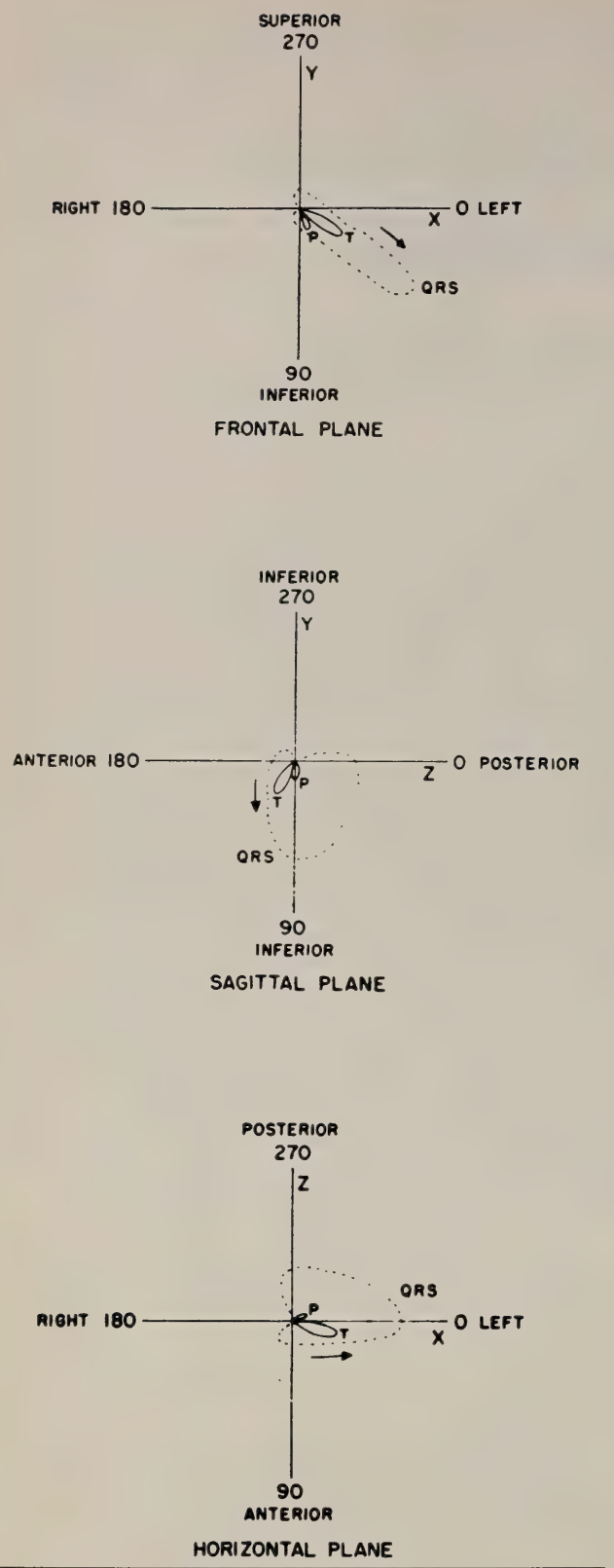


FIG. 1. *Reference system used in this study.*

at the sternal border was used in all cases as the level for the chest leads. Frank's point C, located 45 degrees between the anatomic axes of points A and E, was found by inspection. Recordings were made with the subjects in the supine position. The 12-lead electrocardiogram was taken with a Cambridge direct-writing electrocardiograph immediately after the vectorcardiogram was recorded.

To help achieve technically satisfactory vectorcardiograms, the skin at the electrode sites was massaged to erythema with a tongue blade and Cambridge electrode jelly. If erythema did not occur, the skin was abraded for a maximum of 30 seconds. After electrode attachment and before recording, a five minute period of rest and reassurance reduced somatic tremor. Tremor, commonly arising at the neck electrode, was further minimized by placing a pillow under the head and neck. These precautions were dictated by the fact that fine muscle tremors were the most common cause of unsatisfactory records.

Vectorcardiograms were recorded with the Hart vectorcardiograph (Model PV-3). Frequency response of amplifiers was adjusted to range from 0.1 to 1000 cycles per second. A square wave modulator was calibrated to interrupt the loop 500 times per second so that each dot represented 0.002 second.

Facilities for accurately delineating initial and terminal forces included:

(1) A trace speed sensing device which dimmed the slower-writing portions of the trace to minimize fogging at the "E" point.

(2) A trace shift mechanism which separated out P, QRS, and T loops.

(3) A range of amplification settings from 1.4 to 22 times the conventional 1 cm.for 1 mv. of potential.

The vector loops were ordinarily amplified 4 to 5.6 times to occupy approximately three fourths of the area of the 5 inch oscilloscope screen. Expanded views of the "E" point were routinely photographed for additional accuracy of interpretation. Photographs were made on 3 by 4 inch type 3000-A film with an instrument-mounted Polaroid camera. A blue filter was used to eliminate the necessity for room darkness (Fig. 2).

The angular and magnitude determinations were made directly from the Polaroid prints. A 4 inch diameter transparent protractor was the reference frame for the angular measurements made in accordance with Helm's recommendation.[15] The timed intervals of the QRS loop selected for measurement (Fig. 3) were those known to correspond with successively dominant areas of the ventricular muscle mass during the depolarization process.[16] Checks by three independent observers disclosed an average discrepancy of 5 degrees in the angular measurements. Adjusted figures were agreed before magnitude measurements were carried out. A millimeter rule was used for the magnitude measurements. For accuracy, these readings were re-measured each time the amplification was varied. Corrections were made for the disparity between the magnitude of the image on the oscilloscope screen and its magnitude on the film.

Results

Statistical analysis of angular and magnitude measurements of the P, QRS, and T loops on each plane provided the results presented in Table 2. Mean results and standard deviations of measurements hav-

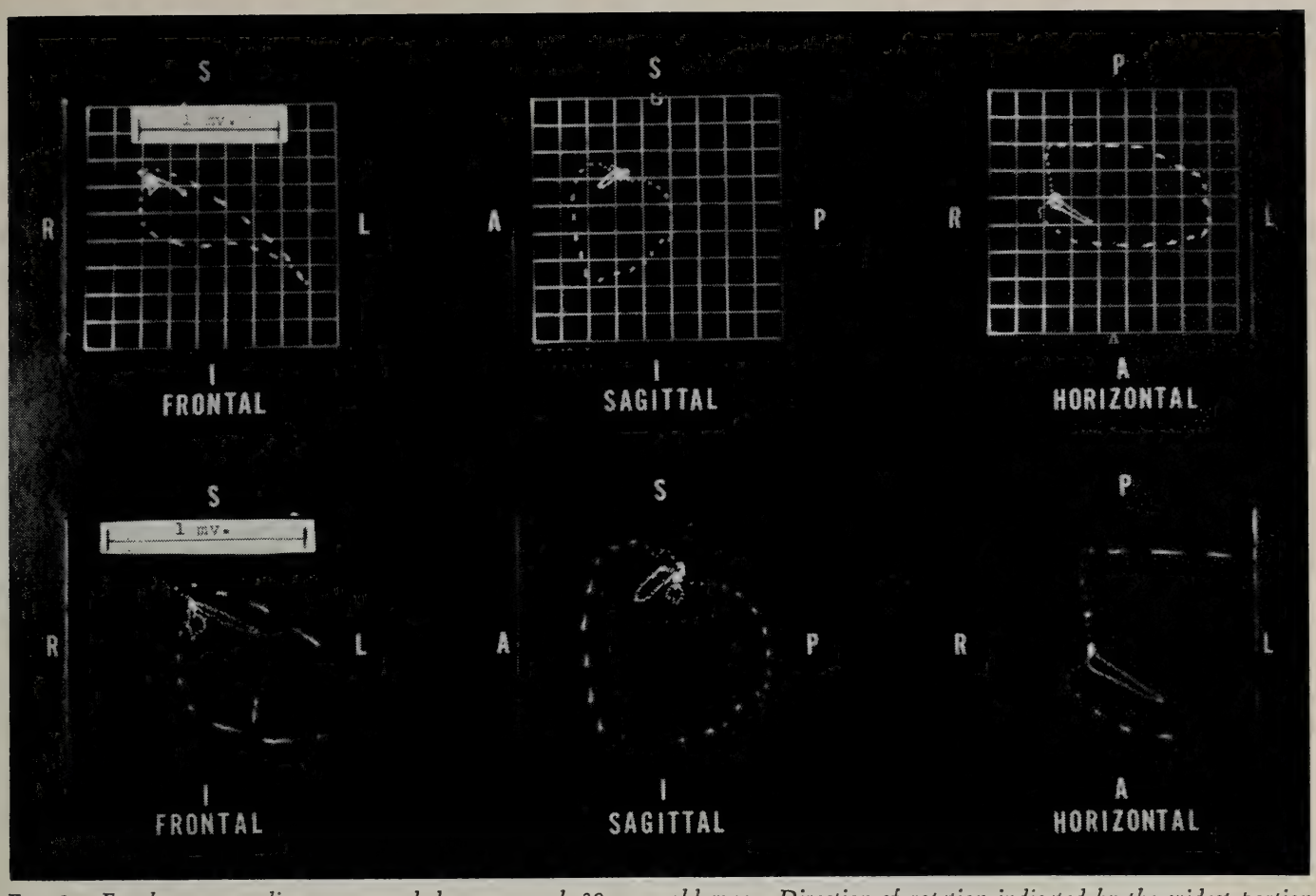


FIG. 2. *Frank vectorcardiogram recorded on normal 30 year old man. Direction of rotation indicated by the widest portion of the tear shaped dots which form the leading edge and interrupt the beam at 0.002 second intervals. Amplified loops recorded without grid are shown in lower half. QRS frontal plane, clockwise; sagittal and horizontal plane, counterclockwise.*

ing a Gaussian distribution are reported. Usable limits for dispersion were determined by the following formula:[19]

$$s = \sqrt{\frac{\Sigma x^2}{N}}$$

Only those results were reported which fell within two standard deviations determined by the formula $\bar{X} \pm 2s$.[19]

Frontal Plane: No significant difference was noted in the location of the maximum QRS vector whether the QRS loop on the frontal plane rotated clockwise or counterclockwise. The QRS maximum vector was more superior for subjects for whom a linear or figure-of-eight loop was recorded than those for whom complete clockwise or counterclockwise loops were recorded.

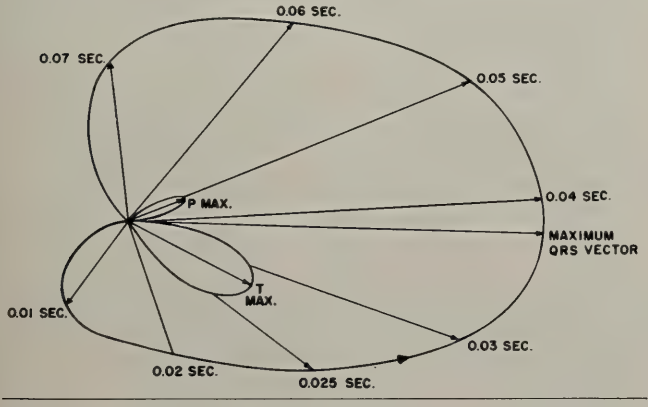


FIG. 3. *Schematic depiction of a normal Frank horizontal plane vector loop. The intervals at which measurements were made are shown.*

The angular locations of the 0.01 and 0.02 sec. QRS forces were eliminated from this study because of wide scatter. Deviations in their magnitudes were, however, within permissible limits.

Sagittal and Horizontal Planes: Superimposability of loops in these mutually perpendicular planes has been shown[13] to be nearly complete with the Frank system. All QRS loops showed only counterclockwise rotation on these planes. With the Frank system, the QRS loop on these two planes will sometimes have its maximum vector in an extremely posterior location.[9] Because of this, the half-area QRS vector has been proposed[9] as a more useful measurement than the maximum QRS vector. It is true that the half-area QRS vector is easy to determine by simple planimetry, that its normal values fall within a restricted range, and that this range is narrower than the range of values for the maximum QRS vector. However, this proposal[17] was originally made for loops obtained with Schmitt's (SVEC III) orthogonal leading system. With this corrected system the maximum QRS vector is more often in an extremely posterior position than with the Frank system. In this study we encountered a posteriorly located maximum

QRS vector in only 3 of the 124 subjects. Because of this infrequent occurrence we did not consider the use of the half-area QRS vector. Our experience in this matter confirms that of other investigators.[10-12]

We have chosen to define the maximum QRS vector as that portion of the QRS loop furthest from the "E" point during the initial 0.05 sec. inscription (Fig. 4). We did so for the following reasons: (1) The relative infrequency of posteriorly located maximum QRS vectors with the Frank system. (2) The propensity for myocardial infarction, exclusive of posteromedial lesions, to alter some portion of the initial 0.05 sec. QRS forces. (3) By so defining and limiting the maximum QRS vector we were able to derive restricted mean results and standard deviations for this vector as well as for the maximum QRS-T angle.

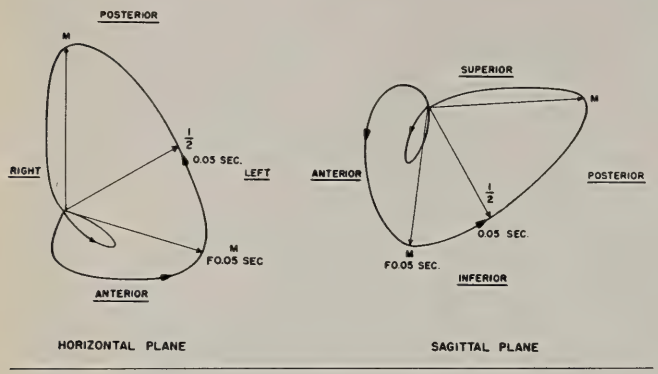


FIG. 4. *Diagram of a horizontal plane loop with the maximum QRS vector having an extreme posterior location. M shows that portion of the first 0.05 sec. QRS forces furthest from the point of origin ("E") for the maximum QRS data determined on the 124 subjects of this study.*

Correspondence between direction of rotation of T loops and QRS loops was noted on all planes (Table 2).

Table 3 is a comparison of results from different laboratories which have used the Frank vectorcardiogram. It is of particular interest to compare our results, where common data exist, with those reported from other laboratories as a valid test of the practical reproducibility of this method of vectorcardiography.

TABLE 2. *Mean Results and Standard Deviations of Angular and Magnitude Measurements of the Frank Vectorcardiogram in 124 Normal Adult Subjects.*

	FRONTAL	SAGITTAL	HORIZONTAL
Rotation of QRS loops (number of cases)	Clockwise (CW) 60 Counterclockwise (CCW) 23 Linear or fig. of 8 (LF/8) 41	Counterclockwise 124	Counterclockwise 124
Maximum QRS vectors			
a. direction (degrees)	43 ± 13 SE* 1.0 (124) † CW 45 ± 13 SE 1.7 (60) CCW 43 ± 12 SE 2.5 (23) LF/8 31 ± 5 SE 0.8 (41)	91 ± 25 SE 2.2 (124)	4 ± 17 SE 1.5 (124)
b. magnitude (millivolts)	1.39 ± 0.34 SE 0.03 (124)	1.02 ± 0.36 SE 0.03 (124)	1.07 ± 0.29 SE 0.026 (124)
0.01 sec. QRS vectors			
a. direction	wide scatter	210 ± 11 SE 1.0 (124)	108 ± 26 SE 2.3 (124)
b. magnitude	.11 ± 0.04 SE 0.01 (100)	0.14 ± .07 SE 0.01 (124)	0.16 ± 0.07 SE 0.01 (124)
0.02 sec. QRS vectors			
a. direction	36 ± 41 SE 4.1 (100)	161 ± 26 SE 2.3 (124)	55 ± 23 SE 2.0 (124)
b. magnitude	0.27 ± 0.19 SE 0.02 (100)	0.32 ± 0.13 SE 0.01 (124)	0.41 ± 0.19 SE 0.02 (124)
0.025 sec. QRS vectors			
a. direction	38 ± 18 SE 1.8 (100)	133 ± 24 SE 2.0 (124)	30 ± 17 SE 1.5 (124)
b. magnitude	0.61 ± 0.29 SE 0.03 (100)	0.49 ± 0.20 SE 0.02 (124)	0.63 ± 0.27 SE 0.02 (124)
0.03 sec. QRS vectors			
a. direction	40 ± 12 SE 1.2 (100)	110 ± 22 SE 2.0 (124)	14 ±15 SE 1.3 (124)
b. magnitude	0.99 ± 0.34 SE 0.03 (100)	0.70 ± 0.25 SE 0.02 (124)	0.86 ± 0.29 SE 0.03 (124)
0.04 sec. QRS vectors			
a. direction	45 ± 21 SE 2.1 (100)	79 ±26 SE 2.3 (124)	343 ± 28 SE 2.5 (124)
b. magnitude	1.05 ± 0.44 SE 0.04 (100)	0.83 ± 0.34 SE 0.03 (124)	0.83 ± 0.35 SE 0.03 (124)
0.05 sec. QRS vectors			
a. direction	NC‡	31 ± 28 SE 2.5 (124)	278 ± 30 SE 2.7 (124)
b. magnitude	NC	0.48 ± 0.17 SE 0.02 (124)	0.44 ± 0.18 SE 0.01 (124)
0.06 sec. QRS vectors			
a. direction	NC	357 ± 26 SE 2.4 (120)	260 ± 29 SE 2.7 (124)
b. magnitude	NC	0.29 ± 0.12 SE 0.01 (120)	0.26 ± 0.16 SE 0.01 (124)
0.07 sec. QRS vectors			
a. direction	NC	4 ± 37 SE 3.6 (110)	252 ±16.7 SE 1.5 (124)
b. magnitude	NC	0.15 ± 0.08 SE 0.01 (110)	0.14 ± 0.08 SE 0.01 (124)
Maximum T. vectors			
a. direction	43 ± 11 SE 1.0 (124)	120 ± 19 SE 1.7 (124)	30 ± 17 SE 1.5 (124)
b. magnitude	0.34 ± 0.10 SE 0.01 (118)	0.29 ± 0.10 SE 0.01 (119)	0.30 ± 0.11 SE 0.01 (124)
QRS-T angle, Degrees between maximum QRS and Maximum T vectors	9 ± 8 SE 0.7 (124)	32 ± 29 SE 2.6 (124)	29 ± 21 SE 1.8 (124)
Maximum P vectors			
a. direction	77 ± 17 SE 1.5 (121)	98 ± 10 SE 1.0 (119)	8 ± 22 SE 1-8 (112)
b. magnitude	0.11 ± 0.04 SE 0.01 (100)	0.12 ± 0.04 SE 0.01 (106)	0.07 ± .02 SE 0.01 (90)
Rotation of T loops (number of cases)	CW (64) CCW (17)	CW (1) CCW (123)	CW (3) CCW (121)

*SE = standard error. Not calculated to less than 0.01 mV. for magnitude.

†Number of subjects. When the number in parentheses is less than 124, it indicates only those subjects for whom exact determinations could be made.

‡NC = not calculated. Terminal QRS vectors are perpendicular to frontal plane and therefore not measurable.

TABLE 3. *Angular and Magnitude Data of Selected Vectors with a Comparison of Other Series (in Degrees and Millivolts)*

	FRONTAL PLANE					SAGITTAL PLANE					HORIZONTAL PLANE				
	Present Series	100 adults McCall et al.[12]	100 adults Walsh et al.[11]	60 young adults Forkner et al.[10]	72 young adults Bristow[6]	Present Series	100 adults McCall et al.[12]	100 adults Walsh et al.[11]	60 young adults Forkner et al.[10]	72 young adults Bristow[6]	Present Series	100 adults McCall et al.[12]	100 adults Walsh et al.[11]	60 young adults Forkner et al.[10]	72 young adults Bristow[6]
QRS Vectors (seconds)															
0.01	NR*	—	—	NR*	—	210 (11)			187 (25)		108 (26)			98 (25.6)	
0.02	36 (41)†		30‡	33 (22.4)		161 (26)		165‡	151 (25)		55 (23)		60‡	50 (24)	
0.03	40 (12)			39 (10.6)		110 (22)			102 (29.5)		14 (15)			8 (15.6)	
0.04	45 (21)			44 (14.2)		79 (26)			65 (24.8)		343 (28)			343 (25)	
QRS Maximum Angle	43 (13)	37 (13)	35‡	40 (10.6)	33 (13)	91 (25)	96 (23)	90‡	65§ (31.2)	39§ (30)	4 (17)	1 (18)	5‡	346§ (30.5)	341§ (17)
magnitude	1.39 (.34)	1.25 (.33)			1.67 (.45)	1.02 (.36)	.81 (.33)			1.24 (.36)	1.07 (.29)	1.03 (.32)			1.58 (.37)
T Maximum Angle	43 (11)			40 (17.7)	37 (12)	120 (19)			104 (27.3)	135 (23)	30 (17)			16 (24.7)	37 (17)
magnitude	.34 (.10)				.47 (.14)	.29 (.10)				.44 (.12)	30 (.11)				.51 (.14)
QRS-T Angle	9 (8)				12 (18)	32 (29)				96§ (39)	29 (21)				71§‡
P Maximum Angle	77 (17)			64 (19.9)		98 (10)			98 (11)		8 (22)			356 (19.4)	

*NR = not reported because of wide scatter.
†Standard deviations in parentheses.
‡Standard deviations not given.
§Series with maximum QRS vector in terminal 0.03 second of loop. See text for discussion.

Discussion

The results of this study show a restricted range of normal values with the Frank vectorcardiogram. They confirm the limited observations available with this system used on normal adults. The angular measurements presented in this study show excellent correlation with those previously reported[11-12] when those had been carried out on subjects of similar age ranges and groups studied in the supine position. This correlation indicates that reproducibility with this method of vectorcardiography is practical. The location of the "R" loop of McCall et al.[12] and the maximum QRS vector reported by Walsh et al.[11] are essentially the same as the maximum QRS vector of the present series.

This indicates that these investigators measured this interval as that portion of the initial 0.05 sec. QRS force farthest from the "E" point. Location of the maximum QRS vector in our series in this manner does not entirely agree with the work of Forkner et al.[10] and Bristow.[9] The explanation may be that these investigators studied young adults and measured the maximum QRS vector when it was posterior to the 0.05 sec. interval.

The study of the angular location of successive, timed, initial intervals of QRS loops as recorded on three mutually perpendicular planes has yielded useful clinical information[18] in myocardial infarction.

This study does more than confirm previous work on the angular location of initial QRS forces. It offers angular data for successive *terminal* QRS vectors for normal subjects as well as magnitude measurements for both initial and terminal timed intervals.

Our magnitude results show occasional disparity when compared with those of previous studies. The few magnitude measurements available for comparison show closest agreement when compared with the results of McCall et al.[12] This emphasizes the need for a uniform method of standardization.

Abnormal magnitudes of initial and terminal QRS forces as well as of the P and T loops exist, whether the angular location is normal or abnormal. Hence these magnitude measurements may sometimes provide the only clue to certain cardiac abnormalities.

The T loop has a consistent direction of rotation. The fact that this direction corresponds with the direction of rotation of the QRS forces has proved helpful in clinical practice. It provides another frame of reference in the consideration of cardiac abnormalities.

Summary

The corrected orthogonal leading system of Frank was used to record vectorcardiograms on 124 normal adult subjects. This method of vectorcardiography is simple to apply and provides a restricted range of normal data.

Angular and magnitude determinations of initial and terminal successive timed intervals of the QRS loop, as well as maximum P and T loop measurements, are presented. An alternative to measure-

ment of the half-area QRS loop is suggested. Data regarding direction of T loop inscription on each plane are provided.

The results are compared with the limited number of reports dealing with this method of vectorcardiography in the normal adult. When subjects of similar age range and groups were studied in the supine position and similar methods of measurement were employed excellent correlation of results was obtained. This would seem to attest to the practical reproducibility of the Frank vectorcardiogram in clinical practice.

Acknowledgment: The authors wish to thank Robert Hamlin, D. V. M., and Phillip T. Knies, M. D., for their counsel in this project and preparation of manuscript.

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INFERIOR MYOCARDIAL INFARCTION. — Seventy-three consecutive patients with a Q wave in Lead III and aVF in the electrocardiogram were studied. Vectorcardiograms were recorded with the use of the Frank system.

In 32 cases the ECG's were compatible with the diagnosis of an inferior myocardial infarction based on a Q wave in Lead III and/or aVF greater than 0.04 second duration and greater than 25 per cent of the amplitude of the R wave. In this group, there were 16 patients with coronary disease and the VCG confirmed the electrocardiographic diagnosis of an infarction in 14 cases. In 13 of the other 16 cases without history of coronary disease the VCG did not suggest the presence of an infarction.

In all 17 cases with questionable electrocardiographic diagnosis of an inferior infarction, and without history of coronary disease, the VCG denied the presence of an infarction. In 18 cases with small Q III or Q aVF the VCG's were within normal limits. In two cases with normal Q III and Q aVF the VCG's did not detect the presence of an infarction in both cases.

The vectorcardiographic diagnosis of an inferior myocardial infarction was based on the superior orientation (at or above 360 degrees) of the 10, 20, 25 and 30-msec vectors in the frontal plane, superior displacement of the maximum QRS vector and clockwise rotation. In the left sagittal plane the 10, 20, 25 and 30-msec vectors were oriented at or above 180 degrees with the loop rotating counterclockwise.

The data presented suggest that vectorcardiography is a useful adjunct to electrocardiography in the diagnosis of an inferior myocardial infarction. — Alberto Benchimol, M. D., Mark W. Roberts, M. D., and E. Grey Dimond, M. D., La Jolla: *California Medicine,* 100:168-174, March 1964.

Adrenal Cysts

A Case Report

ERNEST B. MAINZER, M.D.

ADRENAL cysts are rare and often constitute a surprising finding. They can reach large size before they give rise to serious symptoms. Until November 1959, the total case reports have been about 155.[1] Since then about five have been added.[2] Wahl[3] found nine cases in 13,996 autopsies, Hodges and Ellis[4] report two in 11,000 autopsies in Wayne County General Hospital.

Case Report

In November 1958 during a routine examination of a 33 year old native Caucasian man some hardness and tenderness was noted in the left mesogastrium. There were no symptoms. Radiographic studies were recommended but were not then carried out. He had never been seriously ill.

In June 1961, the patient appeared with the complaint of broken blood vessels on the left anterior chest. Examination showed venectasia on the left upper quadrant of the abdomen. Systemic examination was unchanged from previous times, with the exception of the abdomen. There a mass could be felt, though poorly outlined, in the left upper quadrant. The spleen was not palpable. There was no increased dullness to percussion. The mass seemed to be in depth of the left epigastrium and upper mesogastrium, was tender to pressure, and was difficult to define. Blood pressure was 120/80 and the weight was 250 pounds. The urine examination was normal.

Radiologic interpretation by R. L. Garber, M. D.: "Examination of the abdomen shows a large oval soft tissue mass, 15 by 20 cm., of ground-glass appearance, in the left upper abdomen, which replaces the kidney shadow outline and is thought to represent a large cyst of this kidney. The right kidney is outlined to be normal in size and position. The liver is normal in size, but the spleen cannot be definitely separated from this mass in the left abdomen. The excretory urogram shows normal function of both kidneys, with displacement downward of the left kidney by the large mass in the L. U. Q. which also displaces the body and fundus of the stomach to the right. This is of a uniform density, of ground-glass appearance, and appears to be a large cyst of the left upper pole of the kidney. The rest of the excretory tract is negative." (See Figs. 1, 2, and 3.) Urine and blood findings including blood urea nitrogen were normal. Serologic tests for syphilis were nonreactive.

The mass was excised by Dr. Hall Wiedemer after aspiration of 5 liters of fluid. A very large cystic mass, apparently a single one, appeared in juxtaposition to the upper pole of the left kidney. It was gray and contained on its surface flat yellow structures which appeared to be adrenal tissue. The cyst was very thin-walled and ruptured during an attempt to dissect it from the surrounding structures. About 5 liters of brown cloudy, moderately viscous fluid was aspirated from the cyst and from the retroperitoneal space in which it had escaped. The pathological specimen was examined by Dr. Robert Harsh.

Gross Description

"Multiple portions of fatty tissue total 50.0 ml. in volume. Collapsed thin-walled cyst measures 8.0 cm. in greatest dimension. The wall is partly composed of fibrous tissue and partly of a dense layer of bright yellow cellular tissue measuring no more than 0.3 cm. in thickness. The lining membrane is gray, fibrous, and slightly opaque."

Microscopic Examination and Diagnosis:

"Cyst wall has a flattened, almost indistinguishable lining layer of spindle cells supported by fibrous connective tissue and smooth muscle. Outside this layer are irregular masses of adrenal cortex and medulla. Lipid storage is quite prominent. The cells are well preserved and the adrenal elements themselves are not neoplastic. Separate fatty tissue is not remarkable. Some fibrous connective tissue from the wall of the cyst is disorganized but not typically a new growth. This formation is probably best classified as a cystic hamartoma of the adrenal gland also referred to as myolipofibroma of the adrenal."

Discussion

The first adrenal cyst was reported by Greiselius in 1607. It ruptured and 12 pounds of red fluid and over 2 pounds of fetid clot had mostly escaped into the peritoneal cavity.[5]

Incidence: The cysts occur rarely before the thirtieth year.[6] The average age is 47.8 years.[7] There has been generally a 50 per cent preponderance of women.[1,6] Bilateral cysts occur in about 15 per cent of cases.[6]

Endocrine Dysfunction: This is uncommon. Cushing's syndrome was first reported by Brindley and Chisholm[11] in unilateral cysts. If the function of both adrenals is impaired removal of the cyst and residual gland may initiate an Addisonian crisis. Careful search for bilateral cysts in the patient and in other members of his family is therefore indicated.[6] Such adrenal insufficiency can result from severe adrenal hemorrhage in children and infants with ensuing pseudocysts.[2] Pluriglandular syndrome with thyroid and parathyroid deficiency has been reported,[1] also one cyst in a functioning pheochromocytoma.[7]

Symptoms: Symptoms are not characteristic and are often entirely absent. In large cysts, there is usually dull, persistent pain over the adrenal mass pos-

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teriorly with occasional radiation around anteriorly to the upper abdominal quadrant or epigastrium. Sharp colicky pain was present in two reported cases. Gastrointestinal symptoms such as epigastric distress, abdominal distension, eructation, nausea, vomiting,



FIG. 1. *Excretory urogram showing distal displacement of renal pelvis.*

constipation, etc., are frequently present and are due to pressure of the cyst on the adjacent gastrointestinal tract. Constitutional symptoms such as general malaise, fatigue, weakness, loss of weight, etc., are occasionally noted.[1,6,7] Due to this paucity of symptoms, the majority of these cysts were found only during necropsy.[1,6,7]

Size: The cysts seldom exceed 10 cm. in diameter, but several larger ones have been reported.



FIG. 2. *Retrograde urogram showing displacement of kidney and ureter.*

Gardiner's[8] had a diameter of 30 cm. and weighed 12 kg (26 lbs.) after 8 liters of fluid had been removed during operation, thus having a total weight of 21 kg (46 lbs.). Others had dimensions of 30 cm. in diameter, 25 cm., 21 by 17 by 11.5 cm., and 15 by 13 by 12 cm. Some contained 11, 10, and over 5 liters of fluid.[1,4,6]

Pathogenesis: The following classification by Terrier and Lecène[9] and Levison[10] has been most commonly used.

1. True cysts
2. Cystic adenomas or hamartomas
3. Cystic lymphangiomas
4. Pseudocysts

Hodges et al.[4] have revised the classification as follows:

A. True cysts
   (1) Glandular cysts
   (2) Lymphangioma or lymphangiectasis
   (3) Hemangioma

B. Pseudocysts resulting from:
   (1) Hemorrhage into cortex
   (2) Necrosis and cystic degeneration of benign or malignant primary tumors
   (3) Parasitic infection

Ellis, Dawe and Clagett[7] divide their 12 cysts in the following ways:

1. Serous cysts
2. Pseudocysts
   a. Hemorrhage and necrosis in benign or malignant tumor
   b. Cystic resolution of a hematoma in the absence of neoplasm

The reported cyst falls in the second category of the Terrier and Lecène[9] and Levison[10] classification, being a cystic hamartoma. In the revision by Hodges et al.[4] it would be *B*-2 — necrosis and cystic degeneration of benign tumors. It would be the same according to Ellis et al.[7]

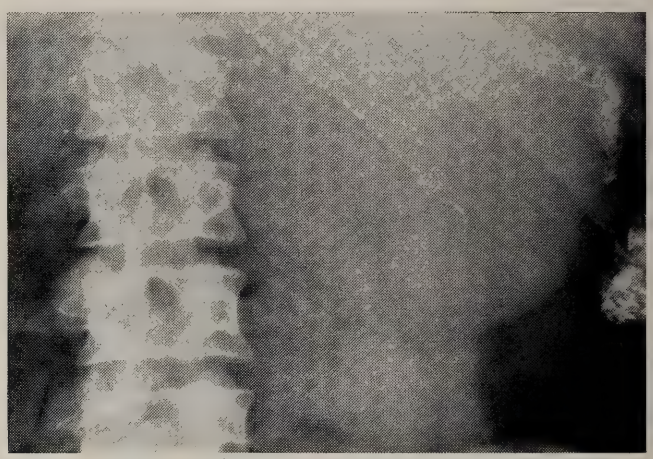


FIG. 3. *Barium enema showing mass with lateral displacement of descending colon.*

Diagnosis: Diagnosis is always difficult and has rarely been made preoperatively, only seven times according to the literature. Preoperative diagnoses have included cyst of spleen, pancreas, liver, kidneys, and mesentery, retroperitoneal tumor, dermoid cyst, renal tumor, empyema of the gallbladder, aneurysm of the splenic artery and disseminated lupus erythematosus, retrocecal appendicitis, and calcified hemangioma of the liver.[1,4,6]

Differential diagnosis further includes hydatid cyst, chylar cyst, urachal cyst, and solid adrenal tumors.[1,4,5,7]

Localization to the adrenal gland is a major step in differentiation. Displacement of adjacent organs such as kidneys, spleen, stomach, descending colon,

—and ureters is helpful in identification. Displacement of the kidney with accompanying distortion of the superior collection structures is a significant localizing indication, which occurs in the majority of the cases, but even exact localization does not ascertain the diagnosis.[7]

Treatment: The treatment is complete excision. The approach is governed by size and location.

Summary

Adrenal cysts are rare and have been mostly found only post mortem. They very seldom cause endocrine dysfunction. They can become huge and then cause symptoms through pressure on and displacement of abdominal viscera.

Radiography, especially the urogram, is the most important diagnostic measure. The cysts are found on either side and have a 50 per cent predominance in women. Diagnosis has rarely been made preoperatively.

An adrenal cyst of 15 by 20 cm. in a man has been reported. Incidence, pathogenesis, symptomatology, diagnosis, and treatment have been discussed.

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CADAVERIC RENAL TRANSPLANTATION. — Twenty patients in terminal renal failure were treated between October 4, 1963, and April 26, 1965, by bilateral nephrectomy, splenectomy, transplantation of a kidney from a cadaver, and administration of the immunosuppressive drugs azathioprine and prednisone. With the exception of ABO blood-group compatibility, donor and recipient were unmatched. Eight of the patients are alive and well with transplants that have been functioning for from three months to one year eight months.

Rejection episodes occurred in all patients who survived the immediate period after transplantation but were all controlled by increased doses of the immunosuppressive agents and by the addition of actinomycin C.

Acute tubular necrosis was encountered in 61 per cent of the renal homografts. This was related to the time during transplantation that the kidney was without a blood-supply and not cooled, rather than to the total period of ischemia. Early function was good in cases where this "warm" time was less than 85 minutes.

When there was poor initial function the toxicity of azathioprine was increased. This toxicity was reduced but adequate immunosuppression still obtained when the dose of azathioprine was lowered to 1.5 mg./kg. daily.

The major cause of death of patients in this series was infection. — J. F. Mowbray, M. B., B. Chir., M. R. C. P., et al, London: *British Medical Journal*, 2:1387-1394 (December 11) 1965.

ATTENTION PROGRAM CHAIRMEN: We are most anxious to receive for consideration manuscripts, abstracts, or news items based upon lectures, symposia, etc., presented to Ohio physicians or those presented by Ohio physicians to other groups. — THE EDITOR.

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Edited by Dr. Scarpelli.

PRESENTATION OF CASE

A NEGRO woman, aged 54, was admitted to Ohio State University Hospital with the chief complaint of weakness of her legs and arms. Three weeks prior to admission she did more than her usual work as a dormitory maid, including making up 27 triple-deck beds. The next day she noted generalized muscle weakness and tenderness which progressed until she was unable to get out of bed or to lift her arms to comb her hair. She was seen by her family physician the next day, who gave her codeine for pain. That same evening the patient noted that her urine became somewhat dark in color. Four days after the onset of symptoms she experienced swelling and tenderness of the hands and fingers, which spontaneously disappeared. The muscle tenderness seemed to decrease up to the time of admission; however, the weakness progressed.

During the three weeks prior to admission the patient lost 10 lbs. She denied any chills or fever, however claimed to have had soaking night sweats during the two weeks prior to admission. The patient stated that she had occasional generalized headaches, however denied any dyspnea, orthopnea, paroxysmal nocturnal dyspnea, palpitations or pedal edema. She had had some anorexia associated with her present illness but no nausea, vomiting, abdominal pain, or melena. The patient had chronic constipation with no change in bowel habits. She had a mild upper respiratory infection with a sore throat but no chills or fever four weeks prior to admission. Because of the progression of the severe muscle weakness the patient came to the emergency room and was admitted.

The patient had been followed in the Outpatient Department intermittently for the past 11 years for hypertension and had been treated with various medications. She stated that she had not been on any medications for five to six months preceding this admission. On her last visit to the Medical Clinic, six months prior to admission, her blood pressure was 220/110 and treatment was started with reserpine and chlorothiazide. An intravenous pyelogram done at that time as part of a hypertension evaluation revealed blunting of minor calyces bilaterally, suggesting chronic pyelonephritis. Chest x-ray done at the same time revealed an enlarged aorta, cardiomegaly with left ventricular predominance, and normal lung fields. The blood urea nitrogen (BUN) was 20 and the creatinine 1.8 mg./100 ml.

The family history was significant in that hypertension was described in a brother, who died at age 45, and a sister, who died at age 49.

Physical Examination

The patient was an obese Negro woman in no apparent acute distress, with a blood pressure of 170/100, pulse rate 110 per minute and regular, respiratory rate 20/min., temperature 99.6°F. The funduscopic examination showed mild arteriolar narrowing with arteriovenous nicking. The neck was supple and showed no venous distention or enlargement of the thyroid. Fine expiratory rales were heard at both lung bases. The left border of cardiac dullness was 2 cm. to the left of the midclavicular line. The cardiac rhythm was regular. A grade I-II/VI apical systolic ejection murmur was heard. A presystolic gallop was present. The abdomen was obese, had no fluid wave. The liver was palpable 3 cm. below the right costal margin. The spleen was not palpable. Rectal examination was normal.

Examination of the extremities showed decreased muscle mass in the legs and marked weakness of all extremities. Only the deltoid muscles were tender at the time of admission. There was superficial thrombophlebitis of the right calf. The deep tendon re-

Submitted February 26, 1966.

flexes were equal and slightly hypoactive bilaterally. No sensory deficits or pathologic reflexes were noted.

Laboratory Data

On admission her hemoglobin was 12.1 Gm., the hematocrit 38 per cent; the white blood cell count was 12,200 with 90 per cent neutrophils. The urine had a specific gravity of 1.010 and contained 20 mg. of protein per 100 ml. and 0-2 white blood cells per high power field. The CO_2 combining power was 19 mEq./liter, the sodium 139, potassium 6.3, and chloride 113 mEq./liter. The fasting blood sugar was 94 mg., the BUN 104 mg., and creatinine 7.2 mg./100 ml. The serum glutamic oxalacetic transaminase (SGOT) was 396 units, the lactic dehydrogenase (LDH) was 1550 units, aldolase 81 units; alkaline phosphatase 4.7 units; total protein 6.2 Gm./100 ml. (albumin 4.0, globulin 2.2); total bilirubin 0.1 mg./100 ml.; calcium 4.3 mEq./liter; uric acid 17.5 mg./100 ml.; cholesterol 285 mg./100 ml. with 69 per cent esterification. The protein-bound iodine was 4 mcg./ 100 ml. The serology was nonreactive for syphilis; latex fixation titer was negative; antistreptolysin O titer was 12 units; C-reactive protein 4 plus; lupus erythematosus preparation negative; urinary vanillomandelic acid was 2 mcg./mg. creatinine.

The electrocardiogram showed sinus tachycardia and possible left ventricular enlargement. The electromyogram was interpreted as indicative of diffuse, moderately severe myopathy.

The chest x-ray showed cardiomegaly with pulmonary congestion and bilateral pleural effusion. Barium enema, upper gastrointestinal and small bowel series were all normal. Bilateral retrograde pyelogram showed slight dilatation of the calyces of the right kidney without any obvious obstruction. The renogram showed good vascularity with poor function bilaterally and marked excretory delay.

Hospital Course

The patient was admitted for evaluation and treatment of diffuse muscle weakness. Repeated urinalyses did not again reveal proteinuria. The BUN climbed steadily although she was not oliguric. The creatinine clearance was 2 cc. per minute. On the tenth hospital day the patient underwent peritoneal dialysis with ten exchanges, which brought her BUN down from 180 to 143 mg., with improvement in the lethargy and nausea that the patient had developed. The hyperkalemia was treated with exchange resins. The enzymes continued to be elevated. Right deltoid skin and muscle biopsies were performed. The skin was reported as normal. The muscle showed focal chronic inflammation and focal myofibrillar atrophy.

After dialysis the patient remained rather stable but no improvement in her muscle strength was noted. Again her BUN rose, leveling off between 160 and 165 mg. with a creatinine between 6.5 and 7 mg. On her 24th hospital day she developed respiratory distress which was partly relieved with nasal oxygen and intermittent positive pressure breathing (IPPB). The following day she suddenly became hypotensive. She was treated with vasopressors and responded briefly, then suddenly developed cardiac standstill. Closed chest massage and tracheal intubation were followed by temporary recovery. However, she again went into cardiac standstill and died, on the 25th hospital day.

CLINICAL DISCUSSION

DR. MENGEL: The patient today is a very interesting one who raises many problems, not all of which will be settled by either me or Dr. Scarpelli. Reading from the protocol, I will reiterate very briefly certain aspects and summate salient features of this patient's illness.

The essence of the history that this patient gave us was that four to five weeks prior to admission she had mild symptoms of upper respiratory infection, followed three weeks prior to admission by considerable physical activity incident to her work as a maid. Following this she noted generalized muscular weakness and tenderness progressing to the point where she was not just unable to carry out her work, but she apparently couldn't raise her arms to comb her hair. This became so severe that she consulted her physician, who prescribed some codeine. At this same time this woman had at least one episode in which her urine became dark. Barring the transient change in her hands with arthralgias and some swelling and perhaps minimal arthritis, this was her immediate present illness. There is the history of soaking night sweats and I would have to say, if indeed this turns out to be tuberculous arteritis of the muscles or tuberculosis of the muscle, I will be surprised.

Dark Urine

I would like to comment on the significance of dark urine. Very frequently when we take histories we are not alert enough to changes that occur in the color of the urine, because when it occurs significantly it may have very important meaning in pointing us in the direction of the proper disease. Dark urine, in addition to just meaning concentrated small urinary volumes, can also occur in settings of hemoglobinuria, myoglobinuria, porphyrin excretion, alcaptonuria, ochronosis, and of course in a variety of other conditions and circumstances where someone has ingested methylene blue tablets, blueberry pie, or a number of other substances that may have no relationship to the illness whatsoever. I was a little disappointed that in the subsequent protocol no statements were made relevant to the color of the urine, while great attention was paid to the BUN, the creatinine, and things that perhaps really wouldn't have pointed us most assuredly in the proper direction.

On the basis of the history I will assume that the patient did not have porphyuria, ochronosis, or alcaptonuria, and that she had not ingested something that would color her urine. So the basic issue at stake

is, Was this *hemoglobinuria* or *myoglobinuria?* Here again we have precious little data to go on. I would like to make two observations relevant to the separation of hemoglobin from myoglobin. The ammonium sulfide separation is not reliable. The spectroscopic bands for these two iron-containing proteins are so close that separation by this means is quite difficult. Since myoglobin migrates more slowly than hemoglobin in an electrical field, on paper electrophoresis a band that has migrated more slowly than the hemoglobin band is diagnostic of myoglobin.

A much easier way that one can utilize is simple visual inspection simultaneously of the plasma and the urine. The myoglobin molecule is about one-quarter of the size of the hemoglobin molecule. Since it is not bound to haptoglobin when it is released into the peripheral circulation, it appears in the urine very quickly. Therefore it very rarely, if ever, accumulates in the plasma. So if you had dark brown urine for examination, and the plasma was clear, you could almost unequivocally say that you had myoglobinuria and not hemoglobinuria. When you are dealing with hemoglobinuria, then the plasma is consistently darkened because of the binding of hemoglobin to haptoglobin. We have no such data, and I was somewhat disappointed that no statement was made later on during the course.

Now the past history I would dismiss quickly. She had had hypertension for a long time. She had a family history of hypertension, and aside from possibly contributing to some aggravations in the kidneys I doubt whether that really points us in the direction of the significant problem.

On physical examination the pertinent features were that she had a temperature of 99.6 — she was febrile. She had some vascular changes in her eyegrounds, her liver was enlarged, and there were a few rales at the lungs. Examination of the extremities showed decreased muscle mass in legs and marked bilateral weakness of both upper and lower extremities, and this very brief statement about the neurological examination leaves me with the impression that the people who saw her believed that there was nothing inherently wrong with her nerves. This may not be an appropriate evaluation, but this is the way I see it at the moment. So all of the data point to a primary muscle disease of some sort.

Now with her laboratory data this case becomes more intriguing. Hematologically, she appeared normal. She had mild proteinuria and elevation of SGOT, LDH, and aldolase enzymes in her serum, which I think for convenience sake may be considered muscle enzymes. I would only point out that the LDH may also be elevated in two other conditions. One is malignancy and often it points toward recognition of an occult neoplasm. An unusual elevation of the LDH relevant to the aldolase and the SGOT did make me at least pause once to consider underlying carcinoma, but only briefly. The proteins were of interest in that there was a normal level of globulin. Obviously, as we come to the differential diagnosis shortly, the possibility that this is a collagen-type disease becomes somewhat remote in the light of these data. I wonder if we could look at the chest x-rays now?

Radiologist's Discussion

Dr. Harris: I will just discuss the positive findings. An intravenous pyelogram done six months before her admission showed kidneys with a moderate excretion and minimal blunting of several of the minor calcyces, and this was corroborated on the bilateral retrogrades done during her hospitalization. An upper G. I. series was entirely normal. A chest film 18 months before her admission showed cardiomegaly with a slightly dilated aorta — changes compatible with the known diagnosis of hypertension. The next film was at the time of her present illness, and the interesting feature here is the poorly defined infiltration in both lower lobes and the absence of pleural fluid. Heart size and contour were unchanged at this examination. The pulmonary infiltrations remained unchanged during the subsequent examinations done during the interval of a week.

Of great interest in this chest film taken shortly before her death is the pulmonary consolidation or atelectasis of the right lower lobe with what may be slight pleural effusion. The differential diagnosis here would be between multiple small pulmonary infarctions and inflammatory disease, either of which would give the small amount of fluid present in this case. In summary then, I feel we are dealing with a minimal bilateral pyelonephritis and infiltrations of both lower lobes, probably inflammatory, although I would certainly want to exclude the possibility of pulmonary infarction.

Renal Dysfunction

Dr. Mengel: Despite her hypertension, this woman did not appear to be suffering from congestive heart failure. The only question I would raise is relative to the renal dysfunction. The marked elevation of the BUN in the absence of other urinary findings is of interest. I just wonder what your thoughts are, Dr. Carter, about the nature of this renal failure. My interpretation has been that if there is renal failure here it must be of a relatively acute nature and perhaps in a diuretic phase, and, second, a good bit of the BUN elevation is probably secondary to acute muscle injury.

Dr. Carter: I think this could be the result of an acute renal insult associated with whatever her illness was. The paucity of findings in the urine sediment is what one would expect in the recovery stage. The relationship of the blood urea nitrogen levels to the recovery phase of acute renal failure is variable, so that it is not uncommon to see the blood urea nitrogen continue to rise despite recovery. One may

deduce from this that recovery is taking place but the filtration rate and the urine output are still diminished.

DR. MENGEL: There are two major questions which must be answered in this case: one, What was the underlying disease that was predominantly affecting her muscles? I think that myopathy was the major feature of this woman's illness; the history, symptomatology, physical examination, electromyographic studies, her subsequent course in the hospital, and the enzymes all point to predominant myopathic changes, and I would like to consider these first.

Myopathies

I have been unwilling to separate muscle diseases by either primary or secondary causes because I don't think this can always be done, and accordingly I classified primaries and secondaries into the following categories: progressive muscular dystrophies, myotonias, metabolic defects, myasthenia gravis, myositides, periodic paralyses with either hyper- or hypokalemic episodes, atrophies of muscle which relate to either denervation, disuse or cachexia, and finally a variety of endocrine abnormalities among which thyroid disease stands out eminently. I think the normal PBI in this patient and the absence of other changes well rule out thyroid disease, and we certainly have no clinical information that could lead us to any of the other endocrinopathies. There is no doubt that progressive muscular dystrophies represent a heterogeneous group of diseases. They undoubtedly are related to some of the problems that we will come to shortly, but in the usual pattern of inherited muscular dystrophies nothing in the course of this patient really points to this group of diseases.

Infections

It is important to consider infections in the cause of muscle disease, and here we have specific infections of trichinosis and toxoplasmosis. Trichinosis is a possibility, but I don't think we have enough information really to document that. Certainly in the setting of certain generalized rickettsial infections and systemic dissemination of tuberculosis muscle pathology has been described. Sarcoid may also give rise to a myopathy. However, there is little to suggest etiologies of this sort in this case.

Myopathy due to altered internal environment, related to either altered chemical status of the muscle or the neuromuscular junction, or to an altered vascular supply, must also be considered. Certainly alterations in potassium and sodium can result in significant myopathy. If you wanted to push the issue you could really look at this woman as a case of uremia who developed a peculiar myopathy, but I think there are too many things that speak against this. The possibility of altered vascular supply is an intriguing one, and the ones we know best are arteritis and polyarteritis nodosa; platelet thrombi in the thrombotic thrombocytopenic purpuras; dissecting aneurysms, now described with myopathies and myoglobinuria; and severe arteriosclerotic vascular disease, perhaps not a direct arteritis but a severe, widespread, diffuse small blood vessel disease of necrotizing type.

Then, finally, there is sickle cell disease, not only in the homozygous but in the heterozygous state, and we have seen at least one patient in whom, during periods of hypoxia, thromboses had formed in situ resulting in infarction of groups of voluntary muscles. I have not had the opportunity to review the biopsy, but the description given us was that of a chronic inflammatory change with degeneration of muscle.

Metabolic Defects

Another group of diseases also to be considered is the so-called metabolic defects of muscle. This could be a glycolytic abnormality involving a phosphorylase deficiency in muscle often referred to as McArdle's syndrome. It is characterized in some instances by a myopathy clearly related to exertion. There is myopathy, myoglobinuria, and indeed death may ensue during the first attack. Direct assay on muscle for phosphorylase activity shows that it is low or absent. Since these patients are unable to make glucose-1-phosphate from glycogen, they do get a rise in their blood lactate after significant exercise. An exercise test measuring serial blood lactates is of great help in establishing this diagnosis. There are many features in this patient's illness which would point in the direction of some glycolytic abnormality. Of interest in this regard is the recent report by Dr. Carl Hinz[1] from Cleveland in the *American Journal of Medicine* describing three patients who clinically appeared to have this syndrome but who did not show muscle phosphorylase deficiency, but rather, metabolic changes which suggested abnormalities in the Kreb's cycle enzymes in muscle. Another important member of this group is primary intermittent myoglobinuria — a disease of unknown etiology. Since myoglobin is lost from muscle in both diseases, a diagnosis of primary myoglobinuria can only be made when it is clear that myoglobinuria is not secondary to a known metabolic disturbance of muscle.

Myositis

A final category that merits mention is the myositides, which includes polymyositis. There seems to be a group of patients who present as a primary idiopathic disease that often comes on after a mild upper respiratory infection which may be associated with a myoglobinuric episode and occasionally associated with exertion. Patients in a second group with the same kind of syndrome show stigmata of the collagen group of diseases. They may have a little pleural effusion, splenomegaly, and mild hematologic abnormalities not dissimilar to the patient under discussion, whose pleural effusion may really reflect a widespread systemic disorder. This group includes dermatomyositis, in which case the skin biopsy should be distinctly abnormal. In this patient the skin biopsy

was reported as normal. The relationship of cancer to dermatomyositis is cited in the literature and it seems to be an unequivocal association. We have no evidence in this particular patient that this is the case.

In conclusion I would say that the most likely possibility in this case is idiopathic primary polymyositis. Perhaps because of the hepatomegaly, and pulmonary changes, this may be related to some underlying collagen disease with a severe vasculitis. Another possibility, although less likely, is that there is a deficient muscle phosphorylase activity to support McArdle's, or changes suggestive of primary myoglobinuria. I think the renal bout represented transient renal injury, perhaps from the bout of myoglobinuria, or more remotely, diffuse renal vascular disease, and we may be seeing a combination of the diuretic phase of renal failure — acute tubular necrosis — and increasing tissue destruction.

Finally we come to the second question: the cause of death. With pulmonary infiltrates, pleural effusion, the bout of respiratory distress on the 24th hospital day which was partly relieved by intermittent positive pressure nasal oxygen, her momentary response to closed chest massage later on, I would think that the most likely cause of death was a massive pulmonary embolism or that perhaps she had had recurrent showers of pulmonary emboli. She may well have had other problems, but with the intermittent respiratory distress I would think this the most likely possibility.

Dr. Carr: I will entertain a period of questions and comments to Dr. Mengel.

Dr. Saslaw: This patient fits the classical picture of what we have seen in dermatomyositis. The fact that she had marked muscular weakness, particularly involving the deltoids, would suggest this diagnosis. These patients frequently develop pneumonias bilaterally due to involvement of muscles of respiration. We have had biopsies on these patients of skin and peripheral voluntary muscles and they showed the pathologic changes consistent with dermatomyositis. In the case at hand, it would be helpful to know if she had difficulty in breathing. Was she using the accessory muscles of respiration?

Dr. Thompson: There was no mention of that. Dr. Wombolt, do you recall any problem?

Dr. Wombolt: She had no recognizable problem with breathing except on the day prior to her death.

Dr. Mengel: I would certainly agree in general that in many respects she had a classic polymyositis syndrome, but with the report of a normal skin biopsy I just think it impossible to entertain dermatomyositis as a diagnosis.

Dr. Saslaw: The reason I chose this diagnosis in the absence of skin lesions is that in my experience respiratory difficulties may be seen in these situations in the early acute phase in the absence of skin involvement.

Dr. Carr: I think this argument is really a semantic one. We read about idiopathic myositis; whether they all fit into the same basket or whether you can split them off into separate entities is a moot point. It would depend upon whether you are a splitter or a lumper, I suppose, but basically, as far as the dermatitis is concerned, it's a completely nonspecific one; second, none was seen, so I would presume none was present; and third, even under the microscope it is far from diagnostic. Dr. Mengel, I was interested in the fact that you could rule out the possibility of an underlying malignancy with little difficulty in a woman over 40 who develops an idiopathic myositis.

Dr. Mengel: The LDH did suggest to me the possibility of an underlying malignancy, but her gastrointestinal tract, kidneys, and pelvis were essentially normal, and we had no findings anywhere to suggest malignancy.

Dr. Carr: Dr. Scarpelli, will you present your findings in this case?

CLINICAL DIAGNOSIS

1. Idiopathic primary polymyositis with myoglobinuria.
2. Myoglobinuric nephropathy, diuretic phase.
3. Hypertension.
4. Massive pulmonary embolism.

PATHOLOGIC DIAGNOSIS

1. Acute polymyositis primarily affecting muscles of the upper extremities, shoulder girdle, and trunk.
2. Focal muscle atrophy and replacement by fat.
3. Hypertensive heart disease.
4. Myocarditis.
5. Bilateral fibrosing alveolitis.
6. Myoglobinuric nephropathy.
7. Arteriolar nephrosclerosis.
8. Uremia.

DISCUSSION OF THE PATHOLOGY

Dr. Scarpelli: I think we are bringing up this case not because it was a very difficult diagnostic problem but to discuss some of the interesting pathology associated with the primary disease. For example, what is the relation of the pulmonary lesions to the muscle? What was responsible for the rapid deterioration and death of this patient?

This was an obese Negro woman measuring 63 in. in length and weighing 200 lbs. Both the pleural and abdominal cavities were free of fluid and adhesions. She had hypertensive heart disease, her heart weighing 475 Gm. and showing a left ventricular hypertrophy. There were no valvular deformities or vegetations. The myocardium was soft and flabby and had a very pale reddish-brown color. The most

outstanding feature of the gross appearance at autopsy was a very curious mottling of her peripheral muscles, especially in the chest and shoulder girdle. The deltoid, intercostal, and rectus muscles were whitish-yellow and appeared not unlike boiled fish muscle. More distal muscle masses were also abnormal but not as severely changed as the proximal ones.

The right lung weighed 475 Gm., the left 425 Gm. On cut surface the lower lobes of both lungs and the right middle lobe showed a diffuse area of grayish-white induration. The remainder of the lungs appeared normal. The liver was enlarged, weighing 1950 Gm.; the cut surface showed a deeply hyperemic parenchyma in which the gross architecture appeared unaltered. Each kidney weighed 175 Gm. The capsule stripped with ease and beneath it the kidney surface was finely granular. The cut surface showed a thickened renal cortex and an indistinct corticomedullary junction and hyperemic medulla.

Microscopic examination of the myocardium showed muscle cell hypertrophy, interstitial fibrosis and perivascular fibrosis. Of considerable interest were the focal interstitial accumulations of polymorphonuclear leukocytes and lymphocytes, especially in the left ventricle and septum. These were of sufficient intensity to warrant a diagnosis of myocarditis. The lungs showed diffuse areas of septal fibrosis with obliteration of alveoli and an interstitial inflammatory exudate consisting of lymphocytes and an occasional plasma cell. There were also foci of acute bronchopneumonia. The submucosal connective tissue of the esophagus was infilterated by numerous lymphocytes and contained dense accumulations of collagen.

The peripheral voluntary muscles showed all stages of polymyositis, from the acute phase consisting predominantly of a polymorphonuclear exudate with focal muscle cell coagulation necrosis with subsarcolemmal nuclear proliferation and phagocytosis of necrotic sarcoplasm, to the chronic changes of muscle atrophy with infiltration by fatty and fibrous connective tissue. Although there were occasional perivascular accumulations of inflammatory cells, these did not appear to be associated with blood vessel injury or vasculitis. Skin from the shoulder obtained at autopsy showed slight edema and a small focal inflammatory exudate of lymphocytes in the dermis. These changes were not of sufficient severity to justify a diagnosis of dermatomyositis.

The kidneys showed an intense inflammatory reaction and edema in the interstitium and dilatation of the distal tubules and collecting ducts by a pale-tan granular material which gave a positive histochemical reaction for iron. There were also focal epithelial cell necrosis and exfoliation of these cells into the tubular lumens. There was a moderate arteriolar nephrosclerosis and the renal glomeruli showed no significant changes.

The primary disease process was polymyositis which by the histology encountered appeared to have been present for some time, with periods of clinical activity and quiescence. However, in view of the absence of historically old reference to muscle disease, it is highly probable that much of the time the polymyositis was subclinical. Noteworthy in this case is the fibrotic lung disease, and since clinical evidence of impaired respiration due to muscle involvement occurred only one day prior to death, the myositis cannot be considered as the indirect cause of the pulmonary disease.

Bilateral fibrosing alveolitis identical to that present in this woman has been reported by Dr. Hepper[2] and his associates at the Mayo Clinic in patients with polymyositis. It is significant that in one of three patients considerable amelioration was observed following corticosteroid therapy. They suggest that it may be that the pulmonary fibrosis is another organ manifestation of the basic pathology responsible for polymyositis. The manner of death in the present case suggested a cardiac cause. This was substantiated by the presence of myocarditis, although hypertensive hypoxia, such as this woman certainly suffered secondary to her pulmonary disease and respiratory muscle weakness could most certainly have led to a fatal cardiac arrhythmia. The uremia, although severe, was not, I believe, immediately responsible for her death.

References

1. Hinz, C. F.; Drucker, W. R., and Larner, J.: Idiopathic Myoglobinuria. *Amer. J. Med.*, 39:49, 1965.
2. Hepper, N. G. G.; Ferguson, R. H., and Howard, F. M., Jr.: Three Types of Pulmonary Involvement in Polymyositis. *Med. Clin. N. Amer.*, 48:1031, 1964.

LIGATION OF THE INFERIOR VENA CAVA is the most effective means of preventing pulmonary embolism. With proper postoperative management this procedure will be followed by a low incidence of disabling sequelae. Further experience with the various methods of plication and compartmentation of the inferior vena cava is necessary before one can determine the possible superiority of these methods over ligation of the inferior vena cava. — Donald C. Nasbeth, M. D., and John M. Moran, M. D., Boston: *The New England Journal of Medicine,* 273:1250-1253, December 2, 1965.


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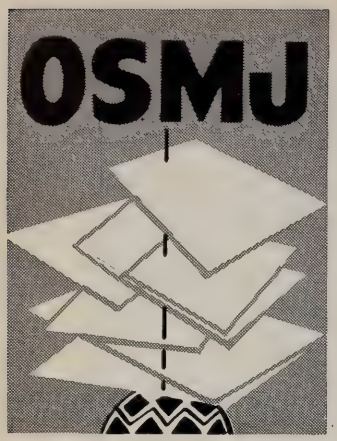
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Research in the Service of Medicine



NEWS AND Organization Section

Proceedings of The Council . . .

Minutes of the Meeting of March 20 in the Columbus Office With Reports of Actions Taken and Other Matters Discussed

A REGULAR meeting of The Council of the Ohio State Medical Association was held March 20, 1966, at the headquarters office, Columbus. All members of The Council were present except Dr. George Newton Spears, Ironton, Councilor of the Ninth District. Others attending the meeting were: Dr. John H. Budd, Cleveland, chairman, Ohio Delegation to the American Medical Association; Mr. Wayne Stichter, Toledo, OSMA legal counsel; Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff.

Minutes Approved

Minutes of the meeting of The Council held February 20, 1966, **were approved** by official action.

Membership Statistics

The following membership statistics were announced by Mr. Page: OSMA membership as of March 16, 1966, 8,903, compared to a total membership of 8,856 on March 16, 1965, and 10,042 on December 31, 1965. He reported that of the 8,903 members, 7,962 were affiliated with the AMA.

Reports of Councilors

The Councilors reported on activities in their respective districts.

Doctor-Draft Call

It was announcd that Ohio is still about 16 physicians short on doctor-draft Call No. 37 and that Call No. 39 will involve 163 Ohio doctors. Interns will be called first.

1966 Annual Meeting

By official action, The Council **approved** the presentation of a certificate to past presidents of the Ohio State Medical Association. The wording and the design of such certificate **were ratified** by The Council.

The Executive Secretary submitted 15 resolutions filed at the OSMA headquarters office by the county medical societies since the February 20th meeting.

A **motion** to proceed with the creation of a Section for Hospital Directors of Medical Education **was approved** by official action.

A resolution honoring Dr. Herbert Morris Platter, Columbus, for his long service to the public and to medicine received the **unanimous approval** of The Council. It was suggested that such resolution be engraved on a plaque and that the plaque be presented at the first session of the House of Delegates, May 24, 1966. The President will request that the rules be suspended and the resolution acted upon immediately upon presentation. (The text of the resolution is published on page 481 in this issue of *The Ohio State Medical Journal.)*

A resolution on dues exemption for financial emergencies, resulting from the passage of Resolution No. 8 by the 1965 House of Delegates, was considered by The Council. By official action, The Council **approved** the wording of the resolution and voted to submit it to the 1966 session of the OSMA House of Delegates in confirmity with the instructions of Resolution No. 8, 1965. (The text of the resolution is published on page 483 in this issue of *The Ohio State Medical Journal.)*

Ohio Medical Indemnity, Inc.

Dr. Tschantz, as chairman, presented the report of the nominating committee appointed by the Presi-

dent to submit the names of candidates for the Board of Directors of Ohio Medical Indemnity, Inc.

By official action, The Council **approved** the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI in April on all business matters coming before that meeting, including the election of directors placed in nomination by The Council at this meeting on March 20, 1966, and subsequently: Dr. H. M. Clodfelter, Columbus, or Dr. Edmond K. Yantes, Wilmington, or Mr. Hart F. Page, Columbus.

By the unanimous consent of The Council, Dr. Meredith, the President-Elect, received permission to appoint as chairman of the Liaison Committee between The Council and Ohio Medical Indemnity Dr. Robert E. Tschantz, Canton, to serve during Dr. Meredith's administration beginning May 27, 1966.

OMI Liaison Report — In connection with the report of the OMI Liaison Committee the following communications were presented to The Council for study:

1. A communication dated March 15 to the Executive Committee of Ohio Medical Indemnity, Inc., from Charles H. Coghlan, Executive Vice President, with regard to the OSMA resolution on the services of anesthesiologists and with the following attachments: Copy of OMI Preferred Certificate of Indemnity Benefits; OMI Claim Form M-42 and OMI Form for Anesthesia Benefits.

2. Minutes of meeting of Research Committee, Ohio Medical Indemnity, Inc., February 16, 1966.

3. Minutes of meeting of Research Committee of Ohio Medical Indemnity, Inc., March 9, 1966, with representatives of the Ohio State Radiological Society.

Riverside Hospital Proposal — A report from a special committee of the Columbus Academy of Medicine which met February 23, 1966, with representatives of Blue Cross and Riverside Hospital, Columbus, regarding a proposed pilot insurance plan, was discussed by The Council. Such plan suggests a preadmission diagnostic workup program with payments made by Blue Cross for medical services involved.

The Council voted to ask Ohio Medical Indemnity, Inc., to move forward with all expedience in the development of policies which will indemnify the patient for the fees of "hospital-based" specialists. In addition, The Council requested that appropriate officials of Ohio Medical Indemnity be invited to appear at the next meeting of The Council, April 23-24, to discuss this matter.

Congress of County Medical Societies

The Council considered a communication from the Academy of Medicine of Cincinnati asking an opinion on the Congress of County Medical Societies. The Council asked the Executive Secretary to inform the Academy that affiliation with this group is a matter for local determination.

Committee Reports

Cancer Coordinating Committee — The Council accepted the report of the Ohio Cancer Coordinating Committee, based on the minutes of a meeting held January 9, 1966.

Committee on Mental Health — Mr. Traphagan presented a report on the meeting of the Committee on Mental Health held January 16. The Council **approved,** in principle, recommendations made by the committee relative to the development of legislation regarding mental health. Further, The Council **approved** the introduction of the following resolution, which embodies these principles, at the 1966 session of the OSMA House of Delegates:

BE IT RESOLVED, That the House of Delegates of The Ohio State Medical Association direct the Association's Committee on Mental Health to develop legislation calling for the establishment of an Ohio Mental Health Council, appointed by the Governor, this Council to consist of seven members with staggered terms at least four of which members shall be doctors of medicine. The duties of The Council, to be defined in the legislation, should include:

(a) The submission of a list of names to the Governor from which he shall appoint the Director of Mental Health;

(b) The development of a list of qualifications for the positions of Director of Mental Health and Commissioners;

(c) The submission of a list of names to the Director from which the Director shall appoint the Commissioners;

(d) The establishment of tenure of office for the Commissioners;

(e) Meeting a given number of times each year;

(f) Making recommendations to the Director and Commissioners upon their request or when it is otherwise deemed desirable;

(g) To make an annual public report on the activities and accomplishments of the Department, and

(h) To provide for itself an adequate staff to carry out its functions; and

BE IT FURTHER RESOLVED, That the House of Delegates direct the Association's Committee on Mental Health to develop separate legislation calling for the establishment of two separate and distinct departments of the State Government, a Department of Mental Health and Retardation and a Department of Correction; and

BE IT FURTHER RESOLVED, That the House of Delegates direct the Association's Committee on Mental Health to develop separate legislation calling for statutory autonomy for mental retardation within the Department of Mental Health; and

BE IT FURTHER RESOLVED, That the principles developed above be the official policy of The Ohio State Medical Association. However the desirability of OSMA sponsorship of such legislation in the 107th General Assembly be determined by The Council.

The Council also **approved** the recommendation of the committee that the Association inform Mrs. Rose Papier, coordinator, Administration on Aging, Ohio Department of Mental Hygiene and Correction, that the Ohio State Medical Association is willing to cooperate in areas where qualified in the administration of the Older Americans' Act of 1965 in Ohio.

The Council also **approved** a recommendation of the committee that it inform the Ohio Psychiatric As-

sociation that the committee will be willing to send a representative or representatives to the OPA's suggested committee to talk and make recommendations regarding possible legislation with regard to criminal responsibility. It was pointed out that these representatives may serve only in an auditive capacity and cannot reflect official OSMA policy.

Acting on another committee recommendation, The Council **approved** a postgraduate meeting to be sponsored by the committee during 1967, the meeting to be two days and that it be self-supporting. This meeting will be a followup to the "First Ohio Congress on Psychological Medicine" held October 24, 1965.

Radiological Advisory Council

A report on the January 18, 1966, meeting of the Radiological Advisory Council, Ohio Department of Health, as presented by Mr. Traphagan, **was accepted** by The Council.

Ohio Association of Blood Banks

A request for the approval of the organization of an Ohio Association of Blood Banks was submitted, along with the proposed Constitution of the Ohio Association of Blood Banks. The constitution was referred to Mr. Wayne Stichter, OSMA legal counsel, for review, and this matter was rescheduled for the April 23-24 meeting of The Council.

Phenylketonuria Regulations

The Council considered a letter of March 3, 1966, from E. W. Arnold, M. D., Ohio Director of Health, which was accompanied by a copy of Amended Substitute Senate Bill No. 19, enacted at the last session of the General Assembly to require phenylketonuria tests for all newborn infants, and a February 28, 1966, draft of proposed Ohio Public Health Council regulations for carrying out the provisions of the law.

By official action, The Council requested that a letter be directed to the Ohio Director of Health, outlining the following objections to the regulations as presently constituted:

1. Only physician directed laboratories should be approved for processing of phenylketonuria tests.

2. Local laboratories both hospital and private should be **encouraged** by the public health council to process PKU screening tests.

3. The Director of Health should approve several acceptable tests and neither he nor the regulation should state a preference for any one or more.

4. The day of collection of the specimen should not even be suggested within the regulation. This is a matter of medical judgment, a decision to be met by an individual physician not by regulation. Further, the suggestion that the specimen be collected on the fourth or fifth day of life will tend to extend hospital stay of newborn in Ohio, for no other reason than the collection of a specimen for a test.

5. Section C (Item 6) would, again, seem to dictate medical judgment. Further, the requirement of repeated serum phenylalanine determinations would seem to go beyond the law.

The question is also raised as to who will pay for the tests when done in a laboratory other than the state laboratory? "We are not referring to the materials which will be supplied by the Ohio Department of Health, we are referring to the cost of time involved in collection, etc."

Workmen's Compensation

Mr. Edgar presented a report of the minutes of the meeting of the Committee on Workmen's Compensation held February 16, 1966.

The committee recommended to The Council that:

1. In keeping with the Principles of Medical Ethics and the laws of Ohio prohibiting corporate practice of medicine, Council requested the Ohio Bureau of Workmen's Compensation to fix a future date, after which the Bureau will require a separate billing for hospital services and a separate billing from physicians for their professional medical services.

2. The Chairman of the committee be authorized to appoint a subcommittee to develop and recommend to BWC a special claim form to be used by physicians in complicated cases.

The recommendations of the committee and the minutes of its meeting **were approved** by Council.

Mr. Edgar presented to The Council a summary of 42 fee bills questioned by the Bureau of Workmen's Compensation under the usual and customary fee program. It was the expression of Council that Councilors must bring to the attention of local medical societies the obligation of review committees to act on "questionable" fee bills submitted by the Bureau of Workmen's Compensation in the same manner as if the committee were mediating a complaint on fees submitted by an individual patient.

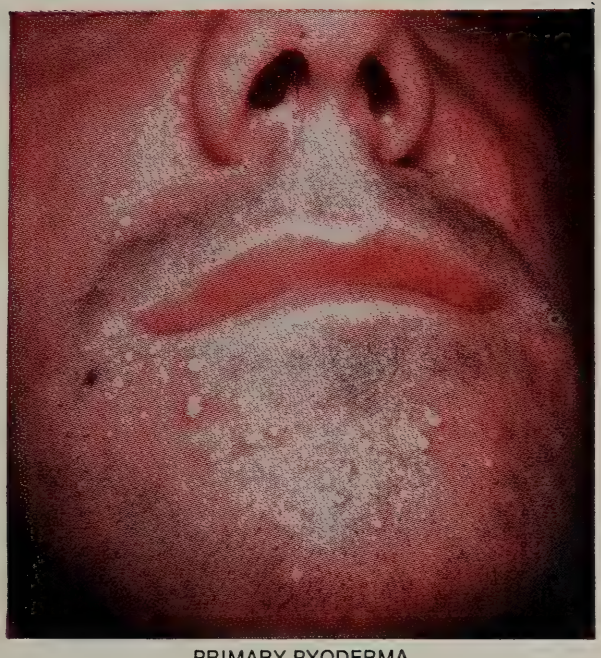
A communication from the legal section of the Bureau of Workmen's Compensation, expressing the opinion that the Bureau could not legally pay hospitals for physicians' services and that such procedures was therefore being discontinued by the Bureau, was brought to the attention of The Council by Mr. Edgar.

Maternal Health Committee — Mr. Gillen reported on a meeting of the Committee on Maternal Health held January 22-23, 1966. The report **was accepted.**

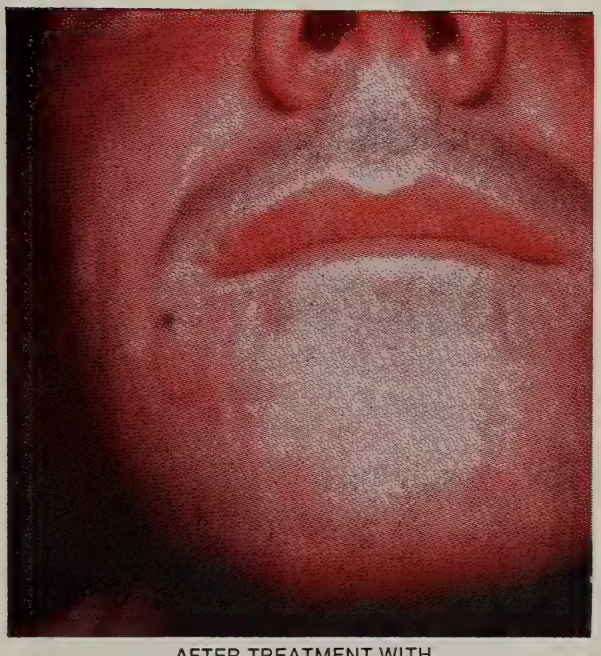
Mr. Gillen announced that Dr. Anthony Ruppersberg, Columbus, chairman of the committee, appeared before the Ohio Hospitalization Benefits Committee on February 23, 1966, to discuss the OSMA policy on the use of obstetrical beds for clean gynecological patients. Dr. Ruppersberg testified before a subcom-

TOPICAL TREATMENT

TYPICAL RESULTS



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For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

mittee of the Ohio Hospitalization Benefits Committee on March 12, 1966.

Hospital Relations Committee

A report on a meeting of the Committee on Hospital Relations, held March 13, 1966, was presented by Mr. Gillen.

Utilization Committees

A statement by the Subcommittee on Utilization Committees was amended to read as follows and subsequently **adopted** by The Council:

1. It is pointed out that based on the demands of the law the factual presentation of the requirements of the Utilization Review Plan prepared by HEW and presented in the *OSMJ* March, 1966, pages 249-251, must be accepted as a condition for approval of the hospital, and the guidelines for organization and activity of utilization committees should be accepted by the medical staff of every hospital.

2. The medical staff of every hospital should have presented to it by a member of that medical staff, the information contained in the above (Standards for Utilization Review Committees Under Medicare) and have open discussion concerning these standards.

3. The criteria for utilization should be determined by the medical staff of each hospital. It is suggested that these criteria be developed to conform with the guidelines of Standard B as presented in the *OSMJ* March, 1966, pages 249-251.

4. It is further suggested that these criteria be acceptable to the medical staff from the standpoint of: (a) the ability of the medical staff to accomplish these reviews on a continuing basis; (b) recording its conclusions when appropriate to meet the requirements of the law; (c) furnishing to the medical staff the results of these reviews.

Staffing Emergency Rooms

The statement of the Hospital Relations Committee on the medical staffing of emergency rooms, which rescinded a previous OSMA policy on this subject, **was amended and adopted.** The statement reads as follows:

The following are recommended as acceptable methods for the medical staffing of emergency rooms:

1. Services by use of bona fide interns and residents in AMA-approved training programs, under the active guidance of the Medical Staff:

2. Services on a fee-for-service basis by one or more licensed physicians approved by the Executive Committee of the Medical Staff of the hospital, with a minimum compensation guaranteed in a manner satisfactory to the Medical Staff.

3. Services by members of the Medical Staff, either voluntary or mandatory, on a fee-for-service or gratuitous basis, with the method of billing for professional services being direct billing by the physician for his services.

4. Services by licensed physicians employed by a medical partnership or corporation, approved by the Executive Committee of the Medical Staff, and composed of all or part of the members of the Medical Staff, billing and remuneration for such professional services to be on any mutually satisfactory arrangement between the medical partnership or corporation and the employed physicians.

Hospital Based Physicians

The committee submitted its review of eight principles for reimbursement of hospital-based physicians as announced by the Social Security Administration. The recommendations of the committee were amended and **adopted** as follows:

PRINCIPLE NO. 1: "It is not the function of the health insurance program to determine the arrangement which a hospital and a hospital-based physician may enter into for the compensation of the physician."

Recommendation: The OSMA is in agreement with the principle as stated. However, the basis for contractual relationships between physicians and hospitals must be in keeping with the laws and with the Principles of Medical Ethics of the American Medical Association.

PRINCIPLE NO. 2: "Whatever the arrangement may be between hospital and physician, the law requires that medical and surgical services rendered to a covered individual by a hospital-based physician be reimbursed only under the supplementary medical insurance program. The costs to a hospital for services furnished in a hospital by a physician which are not professional services to a patient will be included in the reasonable cost reimbursement under the hospital insurance program."

Recommendation: This statement is in accord with OSMA policy. The law requires that medical and surgical services be reimbursed only under the supplementary medical insurance program. Pathology and radiology, as other hospital-based specialties, are practices of medicine and, as such, are medical services.

PRINCIPLE NO. 3: "A professional service rendered by a physician to a patient that can be reimbursed only under the medical insurance program means an identifiable service requiring performance by a physician in person, which contributes to the diagnosis of the condition of the patient with respect to whom the charge under the medical treatment program is to be recognized, or contributes to the treatment of such patient."

Recommendation: It is felt that no discussion of this principle is necessary. However, it should be pointed out that the *Directory of Medical Specialists* (Marquis, 1955-66), page 1005, defines pathology

as "that specialty of the practice of medicine dealing with the causes and nature of disease, which contributes to diagnosis, prognosis and treatment through knowledge gained by laboratory applications of the biologic, chemical or physical sciences to man, or material obtained from man."

PRINCIPLE NO. 4: "For purposes of reimbursement, the Government will respect, within reasonable limits, an agreement between a hospital and a physician concerning the portion of the physician's compensation which is to be attributed to the care of individual patients and the portion which is to be attributed to service to the institution. If they fail to agree, or if their agreement appears unreasonable, it will be the function of the fiscal intermediary handling payments under the hospital insurance program and the carriers handling payments under the medical insurance program to resolve the issue — by negotiation if possible, otherwise by time studies or other suitable methods."

Recommendation: It is the opinion of the OSMA that this arrangement does not provide the physician with equal representation in the arbitration procedure specified. Therefore, it is recommended that this principle be amended to provide for mediation by the Executive Committee of the Medical Staff, with the approval of the hospital board of trustees, and the recommendations of this Committee forwarded to the fiscal intermediary for implementation.

PRINCIPLE NO. 5: "Once the portion of a physician's compensation attributable to professional services to medical insurance beneficiaries has been determined, a schedule of charges can be developed. To be deemed reasonable, the charges should be designed to yield him in the aggregate, as nearly as may be possible, an amount equal to such portion of his compensation. As among the patients to be charged (identifiable in accordance with Principle No. 3), the allocation of charges may be based on a schedule of relative values, on a uniform percentage of the charges made by the hospital or the physician to other patients for both profesisonal and supporting components of the services, or on another method approved by the carrier as equitable."

Recommendation: Strike out all of the lines beginning with "the allocation of changes" and ending with "approved by the carrier as equitable." Substitute in lieu thereof, "the usual and customary fee as determined by the individual physician will apply."

PRINCIPLE NO. 6: "Where a hospital-based physician himself bears some or all of the cost of operation of a hospital department *and* bills his patients directly rather than through the hospital, the reasonable charges for his services recognized under the medical insurance program will reflect the costs so borne by him. Where all of the costs are borne by the physician, charges heretofore established for such services by agreement between the physician and the hospital may be acceptable as reasonable charges for purposes of the medical insurance program, but they will require adjustment either upward or downward if the hospital has been bearing a cost significantly greater or less than its share of the proceeds of such charges."

Recommendation: No recommendation is offered.

PRINCIPLE NO. 7: "Hospitals and hospital-based physicians will be required to keep records and be prepared to furnish information which can substantiate the agreements they enter into with respect to the allocation of the compensation of the physicians."

Recommendation: No comment is offered regarding Principle No. 7.

PRINCIPLE NO. 8: "Nothing in the foregoing principles restricts the right of the physician (in the absence of his acceptance of an assignment by the patient) to determine the amount of his charge to the patient for his services, or restricts the hospital and the physician in providing for disposition of the payments received from the Government and the beneficiaries under the program as they may agree upon. The total costs of services to inpatients and outpatients prior to the inauguration of this program should not be increased solely by reason of the requirement for division of payments for such services between the hospital insurance program and the medical insurance program."

Recommendation: It should be brought to the attention of the physician that the acceptance of an assignment involves the waiver of certain rights with regard to charging his usual and customary fee.

Material from Heart Association Approved

Material on the "Prevention of Rheumatic Fever" and "Prevention of Bacterial Endocarditis," submitted by the Ohio State Heart Association, **was approved.**

American Medical Association

A letter concerning a proposed increase of $25 in the annual AMA membership dues was rescheduled for discussion at the meeting on April 23-24.

The Council voted to nominate Dr. John H. Budd, Cleveland, chairman of the Ohio Delegation to the AMA, for membership on the AMA Council on Medical Service.

It was the Council's decision to nominate Dr. Henry A. Crawford, Cleveland, President of the Ohio State Medical Association, for membership on the AMA Council on National Security.

The Executive Secretary was instructed to notify the American Medical Association that in connection with a communication of February 28, 1966, from Mr. Leo E. Brown with regard to arrangements for the AMA President's Reception, it is the expression

of The Council that the Ohio State Medical Association and the American Medical Association cosponsor the reception with each association paying one-half of the expenses.

The staff was instructed to reserve a large double-size display room with measurements of 17 by 42 feet on the seventh, eighth or ninth floor of the Palmer House as described in a letter from Mr. George Larson, February 14, 1966.

The Council requested that Dr. Budd, chairman of the Ohio Delegation, establish a schedule of hours when the hospitality room is to be manned by the delegates.

The Council **approved** the following resolutions and instructed the Executive Secretary to submit them to the American Medical Association for consideration at the Annual Meeting of the AMA House of Delegates, June 26, 1966:

Quarterly Sessions for AMA House of Delegates

WHEREAS, Business before the House of Delegates of the American Medical Association each year becomes of greater volume and importance; and

WHEREAS, The delegates are faced with problems of lack of time for in depth discussion of resolutions which are placed before the House; and

WHEREAS, A huge array of activities at the Clinical and Annual Meetings of the delegates tends to interfere with the opportunity for concentration on the important matters involved in the resolutions submitted; therefore be it

RESOLVED, That the House of Delegates of the American Medical Association meet four times each year in Chicago to conduct the business of the American Medical Association; and be it further

RESOLVED, That the Clinical and Annual Meetings of the House be continued as ceremonial and election meetings and only such business as is necessary be conducted at these sessions.

Hearings before AMA Councils and Committees

WHEREAS, A frequent disposition of AMA House of Delegates resolutions is to refer them to the Board of Trustees or to Councils or Committees; and

WHEREAS, Adequate and equitable consideration would be assisted by presentation of the case for the resolutions by the proposing individual or delegation; therefore be it

RESOLVED, That it be established as policy of the American Medical Association that when resolutions are referred by the AMA House of Delegates to Board of Trustees, Committees or Councils of the Association, an invitation be extended to representatives of the introducing delegation to participate in hearings or discussions of such resolutions.

Eligibility of Osteopathic Physicians for Internship and Residency Programs

WHEREAS, The American Medical Association has seen fit to make ethical the association between its members and those osteopaths who practice "Scientific Medicine"; and

WHEREAS, The evaluation of an osteopathic physician will remain difficult because his own training programs have not received accreditation by the appropriate committees of the American Medical Association; and

WHEREAS, If it were possible for the graduate of an osteopathic school to receive internship and residency training in an AMA approved program, he could then be judged on the basis of his demonstrated abilities to practice scientific medicine; and

WHEREAS, Graduates of schools of osteopathy who do not hold M. D. degrees are not eligible for appointment to internships or residencies approved by the Council on Medical Education of the AMA; therefore be it

RESOLVED, That the House of Delegates of the American Medical Association instruct the Council on Medical Education to develop a method whereby qualifications of osteopathic physicians who are willing to subscribe to the Principles of Medical Ethics of the American Medical Association and who express the wish to join a component county medical society may be evaluated in order to determine eligibility for intern and residency training in AMA approved hospital programs, without jeopardizing the hospital's accreditation status.

Government Medical Care Programs

The Council adopted a statement with regard to government medical care programs and directed that it be submitted to the membership as Medicare Newsletter No. 3, and that copies be sent to the 50 state medical societies and to the *AMA News.* (The text of the statement is published on page 492 in this issue of *The Ohio State Medical Journal.)*

Generic Equivalent Drugs

A letter from the Pharmaceutical Manufacturers Association, Washington, D. C., regarding the use of "generic equivalent" drugs, was referred to the Committee on Public Relations and Economics.

Hospital Signs on Highways

The Council voted to support a recommendation that Ohio highways and interstate highways be marked to indicate the location of the nearest hospital equipped with emergency facilities.

Request from Practical Nurse Association

The Council **approved** a request from the Practical Nurse Association for the appointment of a representative of the Ohio State Medical Association to its state advisory committee and authorized the President to make this appointment.

OSMA Group Term Life Insurance Plan

Printed information with regard to the increase in coverage available under the OSMA group term life insurance plan was submitted to The Council by Turner & Shepard, Inc., Columbus.

Investment Program for Physicians

An investment program for physicians suggested by Messrs. Jacob Shawan and Wayne Lewis, Columbus, was presented by Dr. Fulton. This matter was referred to the Insurance Committee for study.

The next meeting of The Council was set for 3:00 p. m., Saturday, April 23, and for Sunday, April 24, with no evening meeting Saturday.

Attest: HART F. PAGE
Executive Secretary

Resolutions Which Will Be Considered At the 1966 Annual Meeting

HERE are the texts of resolutions which will be presented for consideration of the House of Delegates at the 1966 Annual Meeting of the Ohio State Medical Association, May 24-28, in Cleveland. These resolutions were received at the Columbus Office on or before March 25, thereby meeting the 60-day deadline. No resolution which failed to meet the 60-day deadline may be introduced unless the sponsor secures at least a two-thirds consent vote of the delegates present at the meeting.

Copies of all resolutions presented to the Columbus Office have been sent to the individual Delegates and Alternate Delegates so that they may discuss them with their county medical societies, if they care to do so.

A resolution to be considered by the House of Delegates must be typed in triplicate; introduced by a delegate or his duly accredited alternate seated in his place; and introduced at the first session of the House of Delegates. This procedure must be followed even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

Sessions of the House of Delegates will be as follows: First Session, Tuesday, May 24, starting with registration at 5:00 P. M. in the Gold Room Assembly, followed by a complimentary dinner at 6:00 P. M. in the Whitehall Room with business session starting at 7:30 P. M. in the Gold Room, all on Mezzanine Floor of the Sheraton-Cleveland Hotel. Final Session will be held on Friday, May 27, at 9:00 A. M. in the Gold Room, Mezzanine Floor, followed by a complimentary luncheon for the Delegates, Alternates and Council of the Ohio State Medical Association in the Whitehall Room, Mezzanine Floor. Meetings of the Resolutions Committees will be held all day on Wednesday, May 25, and on Thursday, May 26, if necessary.

RESOLUTION NO. 1

Herbert Morris Platter, M. D.

(By The Council of the Ohio State Medical Association)

WHEREAS, Herbert Morris Platter, M D., served the citizens of Ohio as Secretary of the State Medical Board of Ohio from 1917 through 1965, and has been a symbol of the purposes of this Association in promoting the science and art of medicine and the protection of public health, and

WHEREAS, Dr. Platter:

Conducted statewide investigations into epidemics of typhoid, scarlet fever and polio in 1908;

Established the first health program for the Columbus, Ohio, Public Schools in 1913;

Compiled the first Public Health Code for the State of Ohio in 1914;

Served as President of the Ohio State Medical Association in 1932-1933;

In 1964 was presented a Certificate of Merit by the American Medical Association for his initiation of the first scientific exhibit to be shown at an AMA Convention, held in Columbus in 1899;

Was awarded a certificate of appreciation by the President of the United States and was awarded a bronze plaque of recognition by the Federation of State Medical Boards of the United States in 1964, NOW THEREFORE BE IT

RESOLVED, that this 1966 Annual Meeting of the Ohio State Medical Association be dedicated to Herbert Morris Platter, M. D., in appreciation for his many years of service, as a physician and a citizen, to the people of Ohio, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association and the physicians of Ohio hereby express their admiration and gratitude to Dr. Platter for his outstanding leadership, guidance and counsel.

RESOLUTION NO. 2

Dues Exemption for Financial Emergencies

(By The Council of the Ohio State Medical Association)

WHEREAS, Amended Resolution No. 8, as adopted by the 1965 OSMA House of Delegates, has directed that an appropriate amendment regarding dues exemption for financial emergencies be prepared by the legal counsel, under the supervision of The Council of the Ohio State Medical Association, for submission to the 1966 OSMA House of Delegates, the following resolution is offered in compliance therewith: THEREFORE BE IT

RESOLVED, that Section 1 of Chapter 2 of the By-Laws of this Association be amended and supplemented by adding at the end thereof the following paragraph:

A member of this Association for whom payment of his regular dues in this Association constitutes a financial hardship may request The Council of this Association for an adjustment of dues. Such request shall be in writing, signed by such member and filed with the secretary of such member's local medical society. If the society, or the council of the society, finds that payment by such member of his regular dues in this Association shall constitute a financial hardship and certifies such finding to The Council of this Association, The Council will make such adjustment of his OSMA dues for such period of time, and subject to such conditions, as The Council may deem appropriate and advisable.

RESOLUTION NO. 3

Mental Health Legislation

(By The Council of the Ohio State Medical Association)

BE IT RESOLVED, that the House of Delegates of the Ohio State Medical Association direct the Association's Committee on Mental Health to develop legislation calling for the establishment of an Ohio Mental Health Council, appointed by the Governor, this Council to consist of seven members, at least four of whom shall be doctors of

medicine. The duties of The Council, to be defined in the legislation, should include:

(a) The submission of a list of names to the Governor from which he shall appoint the Director of Mental Health;

(b) The development of a list of qualifications for the positions of Director of Mental Health and Commissioners;

(c) The submission of a list of names to the director from which the director shall appoint the commissioners;

(d) The establishment of tenure of office for the commissioners;

(e) Meeting a given number of times each year;

(f) Making recommendations to the director and commissioners upon their request or when it is otherwise deemed desirable;

(g) To make an annual public report on the activities and accomplishments of the department, and

(h) To provide for itself an adequate staff to carry out its functions, AND BE IT FURTHER

RESOLVED, that the House of Delegates direct the Association's Committee on Mental Health to develop separate legislation calling for the establishment of two separate and distinct departments of the State Government, a Department of Mental Health and Retardation and a Department of Correction, AND BE IT FURTHER

RESOLVED, the House of Delegates direct the Association's Committee on Mental Health to develop separate legislation calling for statutory autonomy for mental retardation within the Department of Mental Health, AND BE IT FURTHER

RESOLVED, that the principles developed above be the official policy of the Ohio State Medical Association. However, the desirability of OSMA sponsorship of such legislation in the 107th General Assembly be determined by The Council.

RESOLUTION NO. 4

For Reorganization of Ohio State Mental Health Activities

(By the Academy of Medicine of Cleveland)

PREAMBLE

WHEREAS, Ohio State facilities for treatment of mental illnesses are supervised by a Director of Mental Hygiene and Correction who also oversees the penal system, thus linking the mentally ill and criminals under one system to the detriment of both, it is believed that creation of a separate Department for Mental Health would be a major step toward providing more nearly adequate facilities for this State of Ohio. THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association take steps to initiate and to support in the next session of the Ohio Legislature, legislation which will

(1) Create a separate Department of Mental Health in the State of Ohio;

(2) Establish a position of "Director of Mental Health" with cabinet status; and

(3) Establish a Board of Mental Health composed of 5 to 7 members appointed by the Governor, who shall serve overlapping terms of not less than 3 years and at least 3 of whom shall be physicians of recognized competence in the care of the mentally ill, AND BE IT FURTHER

RESOLVED, that said Board of Mental Health shall have at least the following functions:

(1) Advise and assist in the establishment and implementation of policies for the Department of Mental Health.

(2) Recommend to the Governor candidates for the position of Director of the Department of Mental Health.

(3) Meet several times yearly to consider all matters pertinent to effective function of the Department of Mental Health.

(4) Submit to the Governor semiannual reports which shall be made public.

RESOLUTION NO. 5

Policy Statement on Services to the Mentally Ill

(By the Delegates of the Summit County Medical Society)

WHEREAS, the Ohio State Medical Association, representing the physicians of Ohio, has always acknowledged its responsibility to promote improved services to the ill, and

WHEREAS, in recent years the more effective measures for treatment of mental and emotional illness have been established, and

WHEREAS, we believe that an informed citizenry is essential to expanding the application of these treatment methods, THEREFORE BE IT

RESOLVED, that this association adopt the following statement of position and actively encourage and, where necessary, seek sponsorship for legislation to effect the changes to wit:

"It is the position of the OSMA that service to the mentally ill under public auspices must be improved.

"In order to provide improved service to the citizens of this state, we will seek to have the Ohio General Assembly enact measures which will alter the structure of the state agency providing such service and place more responsibility in the local community for the conduct of mental health programs.

"We believe this can most effectively be accomplished by altering the statutes to provide, firstly, for a Department of Mental Health not related to correctional institutions, directed by a properly qualified doctor of medicine. The director would be nominated to the Governor by a State Mental Health Board which itself would be appointed by the Governor on a rotating basis. The State Mental Health Board, working in conjunction with the director, would establish policies and programs which would permit careful professional planning and continuity of program. The Department of Mental Health should establish assistant directors for the various divisions, and Mental Retardation should be a major division.

"Secondly, we believe that there should be adoption of a Community Mental Health Services Act which places in the local community the responsibility for specific treatment programs. Such programs have now been enacted in 20 other states and have improved the services provided since they are tailored to the ill person in the community rather than to efficient means of providing for the masses. The determination as to needed services and facilities would be developed in the community with appropriate assistance from the county medical society."

RESOLUTION NO. 6

Admissions of Mentally Retarded Children

(By the Putnam County Medical Society)

PREAMBLE

Since the State of Ohio assumes the care and treatment of the mentally retarded children and there is a marked limit as to admissions, and since many small counties with high birth rates can only admit two (2) children per year, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association encourage a more equitable method of admission to the Mentally Retarded Children's Hospital or that the institution be enlarged.

RESOLUTION NO. 7

Method of Payment to Physicians from Government Agencies

(By the Stark County Medical Society)

WHEREAS, Ohio has been one of the leaders in this country in offering a comprehensive type of indemnity insurance which pays the individual physician's usual and customary fee for those persons with income below $7,500. Recently National Blue Shield has given national publicity

to a service contract alleged to be a prevailing usual and customary fee, and

WHEREAS, Ohio Medical Indemnity in a special Newsletter dated February 2, 1966, pointed out very important differences in these two programs, as follows:

(a) Ohio's individual physician's usual and customary fee program is an indemnity type insurance; national prevailing fee is a service contract.

(b) Ohio's individual physician's usual and customary fee program pays **all** physicians their usual and customary charges to persons with incomes of $7,500 or less in counties where it is offered. In national prevailing fee programs, the physicians first must submit a detailed report on all their usual charges and only those physicians are included whose charges fall within the 90th percentile of charges submitted.

(c) Under Ohio's individual physician's usual and customary program, physicians **do not have** to sign contracts to participate. Under the national prevailing usual and customary program only those **physicians** whose charges fall within the 90th percentile of the areawide charge are offered a contract to sign and these physicians must then sign a **service** contract and agree to accept the payment from the carrier as payment in full, and

WHEREAS, Ohio's Resolution No. 5, approved at the special meeting of the AMA in October, 1965, stated that physicians shall be entitled to reasonable remuneration as provided by P. L. 89-97 and this shall be interpreted as the individual physician's usual and customary fee for the care of private patients, and

WHEREAS, it is most important for the physicians in Ohio and the nation not to confuse these two very basically different concepts, THEREFORE BE IT

RESOLVED, that further publicity be given to the physicians in Ohio on these two different concepts, AND BE IT FURTHER

RESOLVED, that Ohio's delegation to the American Medical Association is hereby instructed to present in resolution form Ohio's individual physician's usual and customary fee concept as the one of choice in dealing with government agencies.

RESOLUTION NO. 8

Usual and Customary Fee

(By the Huron County Medical Society)

WHEREAS, the House of Delegates at the American Medical Association Convention in June, 1965, adopted the position that, "When Government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement of the services of physicians participating in government-supported programs should be on the basis of usual and customary fees," and

WHEREAS, the "usual and customary fee" basis "is a proven method of providing service benefits at acceptable cost," — (Carl A. Tiffany, Chicago; consulting actuary for a number of State Medical Associations), and

WHEREAS, AMA House of Delegates adopted an Iowa resolution at the Philadelphia clinical convention November 28 - December 1, 1965, to "reaffirm its support of the usual and customary fee concept as the basis for reimbursing physician participants in government programs," and

WHEREAS, it is unreasonable to be expected to provide charitable services to persons who are the responsibility of government, and

WHEREAS, there is no longer a question of physicians helping financially distressed people who need help — rather, a matter of expecting the government to pay "usual and customary fees" for the health care services promised to its beneficiaries — the people, THEREFORE BE IT

RESOLVED, that starting June 1, 1966, the Ohio State Medical Association advise the Ohio Department of Public Welfare that the physicians of Ohio will expect 100 per cent payment for professional services rendered to welfare recipients — based on the "usual and customary fee" determined by the individual physician.

RESOLUTION NO. 9

Usual and Customary Fees

(By the Mahoning County Medical Society)

WHEREAS, the Bureau of Workmen's Compensation has now accepted the Ohio State Medical Association proposal that the usual and customary fee be applied to compensation recipients, and

WHEREAS, Government agencies pay realistically for all other goods and services and should neither expect nor demand a discount for medical services, and

WHEREAS, each physician should receive a fair fee for his professional services as do others who deal directly with the government, and

WHEREAS, in other areas physicians have convinced government agencies that cut-rate fees are unfair and that these agencies, when they are paying bills for the indigent, should not seek special fee treatment, and

WHEREAS, under the antipoverty program, and in accordance with the policy of the Great Society, each patient, whether governmental or private, should not feel that there is any discrimination because of variation of fees, THEREFORE BE IT

RESOLVED, that the members of the Ohio State Medical Association go on record that they expect their usual or customary fee in the medical and surgical care or treatment of all governmental patients and patients provided for by other third party plans.

RESOLUTION NO. 10

Usual and Customary Fee

(By the Muskingum County Academy of Medicine)

WHEREAS, governmental agencies at all levels, city, county, state, and federal have assumed the obligation for indigent and disabled, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association notify such agencies that the members of the Ohio State Medical Association feel that payment of the individual physicians' usual and customary fee should be made.

RESOLUTION NO. 11

Usual and Customary Fees

(By the Holmes County Medical Society)

WHEREAS, the House of Delegates at the American Medical Association Convention in New York in June, 1965, adopted the position that, "When government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement of the services of physicians participating in government-supported programs should be on the basis of usual and customary fees," and

WHEREAS, the usual and customary fee has been a proven method for providing reimbursement at acceptable cost, and

WHEREAS, the Ohio Bureau of Workmen's Compensation has chosen to authorize the usual and customary fee for services provided to approved Workmen's Compensation cases, and

WHEREAS, it is unreasonable to be expected to provide charitable services to individuals for whom government — state, federal or local — claims responsibility, and

WHEREAS, there is no longer a question of physicians helping financially distressed persons who need help, but rather, a matter of expecting the government to pay "usual

and customary fees" for the health care programs which it has promised to its beneficiaries, THEREFORE BE IT

RESOLVED, that

(1) Starting June 1, 1966, the Ohio State Medical Association advise the Ohio Department of Public Welfare that the physicians of Ohio will expect 100 per cent payment for professional services rendered to welfare clientele — based on the "usual and customary fees" that prevail in any particular locality, and

(2) The clientele covered by the Welfare Department shall include all divisions of the State Department of Public Welfare.

RESOLUTION NO. 12

Usual and Customary Fee

(By the Licking County Medical Society)

WHEREAS, it has been the self-imposed obligation of the medical profession to donate its services freely and gladly, individually and collectively, to the care of the medically indigent, and

WHEREAS, it is now a fact established by Acts of Congress and directives of governmental departments that the government has assumed financial responsibility for the medical care of a large segment of society, and

WHEREAS, the unrealistic fee schedules imposed by state and local governmental agencies have placed an inequitable burden upon a large segment of the medical profession, and

WHEREAS, it is our considered opinion that government — federal, state or local — is no longer an object for charity from the medical profession than it is from any other supplier of goods or services, THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct The Council and the appropriate committees appointed to negotiate with government agencies, to press vigorously for the establishment of usual and customary fees for medical services.

RESOLUTION NO. 13

Medical Benefits for Welfare Cases

(By the Trumbull County Medical Society)

WHEREAS, the fee schedule for the payment of physician services in welfare cases is unreasonably low, and

WHEREAS, the Kerr-Mills Law states that a state cannot be unreasonably restrictive in its medical benefits, and

WHEREAS, the payment of services to indigents at a reduced fee is no longer justified when the government is responsible for their care, and

WHEREAS, welfare-discount rates should give way to full payment of charges consistent with prevailing rates in the community, and

WHEREAS, it is no longer a question of physicians helping financially distressed persons who need help, but it is purely a matter of expecting the government to pay reasonable fees for the health care services promised to its beneficiaries, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association advise the Ohio Department of Public Welfare that members of OSMA will expect usual and customary fees for professional services to welfare clientele beginning July 1, 1966, the date that Part B of the Medicare Law becomes effective.

RESOLUTION NO. 14

Usual and Customary Fee

(By the Butler County Medical Society)

WHEREAS, in addition to the Medicare Program for Social Security beneficiaries, Public Law 89-97 contains under Title XIX a vastly-expanded health care program for public assistance recipients of all ages, and

WHEREAS, the passage of Medicare legislation will vastly change the health economic picture in Ohio with the hospital portion of the Medicare Act not only relieving the Department of Public Welfare of financial commitments to persons over age 65, but also liberalizing amendments to the existing Kerr-Mills Program, and

WHEREAS, the value of medical services shall be determined by the seller and not by the purchaser, and

WHEREAS, no other segment, professional or otherwise, of our population accepts compensation for services rendered at a rate which he deems below the value of his services, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association inform the Ohio Department of Public Welfare that the physicians of Ohio, members of the Ohio State Medical Association, will not treat welfare patients, or patients under any other of its programs, including Title 19: P. L. 89-97, where the fee for payment is arbitrarily set by the Welfare Department, AND THEREFORE BE IT FURTHER

RESOLVED, that the Ohio State Medical Association meet with the State Welfare Department relative to establishing physicians' fees based on the principle of "usual, customary, and reasonable fees."

RESOLUTION NO. 15

Hospital Admission

(By the Mahoning County Medical Society)

WHEREAS, Public Law 89-97 (Medicare) may require federal forms for physician certification of hospital admission, and

WHEREAS, the American Medical Association during its October 2-3, 1965 meeting, adopted the policy that "current practices and customary procedures with respect to certification for hospital admission and care shall be continued under Public Law 89-97," and

WHEREAS, the current admissions practice in most Ohio hospitals is an oral request for bed facilities, followed by the signing of the patient's hospital chart after the patient's admission, and

WHEREAS, hospital admission procedures should be the same for all patients, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association adopt as official policy the principle that in certifying any patient for hospital care, a physician may ethically continue to use the current practice of signing the patient's hospital chart.

RESOLUTION NO. 16

Reimbursement for Services of Hospital-Based Physicians Under Medicare

(By the Lorain County Medical Society)

WHEREAS, the Medicare Law (P. L. 89-97) establishes separate provisions for hospital care and for coverage of physicians' services, and

WHEREAS, the Congress clearly defined the separation between these two provisions by specifically rejecting the Douglas Amendment, which would have impounded those physicians designated as "hospital-based physicians" within that coverage defined only for hospitalization costs, and

WHEREAS, the Social Security Administration has seen fit to unilaterally interpret the law and attempt to force "hospital-based physicians" to accept reimbursement for professional services under the hospitalization provision of the Medicare Law, and

WHEREAS, the national governing bodies of the concerned physician specialists and the American Medical Association have issued directives requiring fee for service arrangements and direct billing of individual patients in the ultimate interest of maintaining the best possible medical care with the least possible interference by professionally unconcerned third parties, and

WHEREAS, relief from the oppressive regulations of the Social Security Administration, which threaten to eventually include any physician who performs any service for a patient in the hospital, requires separation of any

and all physicians from payment for services by a hospital, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association endorse and actively support the position of "hospital-based physicians" in altering whatever hospital contracts as are necessary, so as to establish a normal and ethical relationship (fee for service arrangement with individual billing of all patients) as is and should be the normal and ethical practice for all physicians.

RESOLUTION NO. 17

Physicians, Ethics and the Corporate Practice of Medicine

(By the Stark County Medical Society)

WHEREAS, the Ohio State Medical Association legal counsel has provided an excellent presentation of the ethical and legal aspects of the corporate practice of medicine, this presentation having been sent to all members of this Association February 8, 1966, under the heading of "Special Medicare Newsletter No. 2," and

WHEREAS, Section 4, **Principles of Medical Ethics,** states, "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession," and

WHEREAS, the Judicial Council of the American Medical Association states (1966 Opinions and Reports, Page 16, Section 4, Article 9):

"OBLIGATIONS OF COUNTY MEDICAL SOCIETIES

The Council has emphasized the autonomy of the county society and the fact that such autonomy imposes responsibilities. If medical societies fail to accept and discharge their obligations in matter of ethics, others will assume these obligations by default. The Judicial Council urges county and state societies to adopt critical attitudes toward their programs to "uphold the honor and dignity" of the profession of medicine. These programs must be based on a sound knowledge and understanding of ethical principles. As long as ethical principles are widely and sedulously observed, the reputation of the medical profession will be upheld. The reward will be commensurate with the services rendered in the observation of these ideals. On the other hand, if there is flagrant or even careless disregard of ethical principles, the reputation of the profession of medicine will suffer and its responsibilities and obligations will be usurped by others. (AMA House of Delegates, 1958.)" THEREFORE BE IT

RESOLVED, that this House of Delegates urges each Component Medical Society of this Association to review all medical practice contracts of all physician members to determine the ethical and legal compliance of such contracts in light of legal counsel's opinion, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association Delegates to the American Medical Association are hereby instructed to present a similar resolution before the American Medical Association House of Delegates at the 1966 Annual Convention.

RESOLUTION NO. 18

Removal of Physicians' Services from Hospital Insurance Contracts

(By the Delegates of the Summit County Medical Society)

WHEREAS, Section 1701.03 of the Revised Code of Ohio prohibits the practice of a profession by a lay corporation and Opinion 1751 of the Attorney General of Ohio stated specifically that a corporation, whether or not organized for profit, could not lawfully engage in the practice of medicine in Ohio, and

WHEREAS, Blue Cross has become the major mechanism in Ohio for hospital corporations practicing medicine via employed physicians, and

WHEREAS, this has resulted in the medical specialties of pathology, radiology, anesthesiology and physiatry being looked upon and dealt with as hospital services to the point where the American Hospital Association and elements in the Department of Health, Education, and Welfare have argued for their inclusion under the hospital portion of Public Law 89-97, and

WHEREAS, these efforts jeopardize the continued observance of the principle established in Ohio law of separating professional practice from hospital management, THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct The Council of the OSMA to petition the Director of Insurance, State of Ohio, to require removal from all prepaid hospitalization insurance plans provisions for benefits covering physicians' services, and that this be first accomplished in the case of the major carrier — namely, Blue Cross.

RESOLUTION NO. 19

Assignments Not Acceptable

(By the Lake County Medical Society)

WHEREAS, the ethical propriety of charging a fee for service at the usual and customary level has been accepted by the Ohio State Medical Association, and

WHEREAS, the ethical propriety of direct billing of the patient by the physician has been repeatedly endorsed, and

WHEREAS, the Ohio State Medical Association has joined other professional bodies in visiting censure upon contractual arrangements between a physician and a hospital or a corporation involving modes of collection of the physician's fees by indirect means such that the physician receives his recompense through the hospital or corporation, and

WHEREAS, the physician makes no claim to being an expert in the management of financial problems of his patients, limiting advice to medical matters, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association encourage the physician to eschew collection practices whereby the physician relieves the patient of the direct management of the patient's own financial affairs by virtue of the physician's acceptance of an assignment to a third party for remuneration, this resolve to be implemented by the physician's acceptance of remuneration only from the hand of the patient himself or from the patient's legal guardian.

RESOLUTION NO. 20

Direct Billing

(By the Lake County Medical Society)

WHEREAS, Public Law 89-97 (Medicare) provides that the physician may seek his fee either from the patient directly or from the "carrier" assigned by the patient, according to the physician's own option, and

WHEREAS, this option affords the individual physician a means to exercise his own initiative in setting his own fee for service and, in doing so, encourages the development of a contractual relationship between the individual patient and the individual physician largely free of the encumbrance of the third party "carrier," and

WHEREAS, this professional body has repeatedly and publicly announced its support of measures that support the integrity of that patient-physician relationship in the interest of the best medical care to the individual patient, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association announce its support of that lawful option and endorse direct billing of each patient as the form of fee collection to be preferred, encouraging its members to its exclusive use.

RESOLUTION NO. 21

Medicare

(By the Stark County Medical Society)

WHEREAS, Public Law 89-97 provides the option of direct reimbursement of patients eligible for benefits under Part B of said law, and

WHEREAS, Public Law 569 (Military Dependent's Medical Care Act) 84th Congress, does not provide such an option, and

WHEREAS, the lack of such option destroys the physician-patient relationship, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association strongly recommends that all necessary actions be taken in order to provide that patients eligible for benefits under Public Law 569 be afforded the same option of reimbursement as is provided for patients eligible for benefits under Public Law 89-97, Part B.

RESOLUTION NO. 22

Public Law 89-97 (Medicare)

(By the Stark County Medical Society)

WHEREAS, since Medicare is now the law of the land, it is the avowed purpose of the American Medical Association, through the President, Board of Trustees, and the House of Delegates, to work for the repeal of those portions of the law that will lead to the deterioration in the quality of medical care, disturb that patient-physician relationship and are in conflict with the nine points laid down by the AMA House of Delegates concerning health care legislation in October, 1965, and

WHEREAS, the Houses of Delegates of the American Medical Association and the Ohio State Medical Association have said it would be unethical for any physician to practice any system of medicine that leads to a deterioration in quality or disturbs the patient-physician relationship, THEREFORE BE IT

RESOLVED, the House of Delegates of the Ohio State Medical Association reaffirm these principles as guidelines for all physicians to follow in the trying period ahead.

RESOLUTION NO. 23

Endorsement of the "Open Staff"

(By the Delegates of the Summit County Medical Society)

WHEREAS, Ohio physicians are concerned about the trend in postgraduate medical education which tends to create closed-staff hospitals, and

WHEREAS, we believe this to be a nationwide problem requiring the immediate attention and attempted correction by the American Medical Association, THEREFORE BE IT

RESOLVED, that the Ohio Delegates to the AMA House of Delegates introduce at the next regular session of that body the following resolution:

"Endorsement of the Open Staff"

WHEREAS, the policy of "open staff" in hospitals is believed to provide and encourage the best quality medical care, and

WHEREAS, current emphasis on the educational aspects of training of interns as structured by the Joint Commission on Accreditation of Hospitals and the similar emphasis by specialty boards on the training of residents has tended to cause community hospitals to model their programs after those found in university-affiliated hospitals, and

WHEREAS, in subtle ways such model programs exert pressures which tend to create "closed-staff" hospitals, thereby encroaching on the freedom of many physicians with the potential of reducing the general level of quality of medical service, THEREFORE BE IT

RESOLVED, that the AMA, representative of most physicians, exert its influence so as to assist all hospital staffs in providing excellent training programs and at the same time continuing its efforts to maintain the principle of "open-staff" hospitals.

RESOLUTION NO. 24

Standardized Claims Form

(By the Mahoning County Medical Society)

WHEREAS, under Public Law 89-97 (Medicare) a claim form has been proposed by the Department of Health, Education and Welfare for the implementation of Part B of the Act, and

WHEREAS, the completion of such form together with the physician's signature, may establish precedence with reference to future and even more objectionable forms, and

WHEREAS, it is reasonable to provide essential, medical information for the purpose of reimbursement, and

WHEREAS, a standardized claims form is desirable for all third party claims, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association adopt a standardized claims form, to be used in lieu of any proposed form submitted by the Department of HEW or its fiscal intermediary, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association make available to all its members who desire to use it, a claims form similar to the one attached.

(See Insurance Form on facing page)

RESOLUTION NO. 25

Commendation to OSMA Officers, Ohio's AMA Delegation and Staff of the OSMA

(By the Huron County Medical Society)

WHEREAS, the officers and all members of the Ohio Delegation to the Clinical Convention of the American Medical Association, November, 1965, showed superb resolve in action; put forth untiring efforts and effected many worthwhile causes in the interest of the preservation of the private practice of medicine, and

WHEREAS, they were most loyally complemented and helped by the staff of the Ohio State Medical Association in their efforts to preserve American Medicine, THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association, in behalf of the physicians of Ohio, convey to said officers, members of the Ohio AMA Delegation, and the staff of the Ohio State Medical Association a vote of lasting thanks, gratitude, and appreciation, AND BE IT FURTHER

RESOLVED, that the Physicians of Ohio show undivided allegiance in word, deed, and action, to the able and capable leaders of the Ohio State Medical Association and pledge our help in a common effort to preserve the atmosphere within which is practiced the best quality medical care the world has ever known, possible only under the free enterprise private medical care system.

RESOLUTION NO. 26

Changes in Certificate of Live Birth

(By the Montgomery County Medical Society)

WHEREAS, the knowledge of the incidence of congenital abnormalities at birth is essential, and

WHEREAS, the compilation of the statistics of these abnormalities is vital, and

WHEREAS, prevention can be accomplished only by the study and interpretation of the above, and

WHEREAS, the space allotted on the present live birth certificate is inadequate, and

WHEREAS, this inadequacy is contributing to the failure to record abnormalities, THEREFORE BE IT

RESOLVED, that the Bureau of Vital Statistics be directed to change the form of the present live birth certificate so that adequate space will be provided for the recording of all abnormal findings according to standard medical nomenclature.

RESOLUTION NO. 27

AAPS Essay Contest

(By the Columbus Academy of Medicine)

BE IT RESOLVED, that the House of Delegates of the Ohio State Medical Association endorse the Essay Contest

of the Association of American Physicians and Surgeons with the titles: (1) The Advantages of the American System of Private Medical Care and (2) The Advantages of the American Free Enterprise System.

RESOLUTION NO. 28

In Opposition to the Fluoridation of Public Drinking Water Supplies

(By Joseph G. Crotty, M. D., Delegate, Hamilton County)

WHEREAS, fluorine seems to be conducive to, but not necessarily essential to the normal development of tooth structure in children, and

WHEREAS, there is grave doubt as to the morality and ethics of forced medication in the form of adding such fluorine to the public drinking supplies, and

WHEREAS, water is necessary for life, and

WHEREAS, most people are dependent on public supplies for water, and

WHEREAS, chronic fluorosis, produced by the presence of fluorides in drinking water, may produce mottling, discoloration, and other damage to tooth structure, as well as to the general health of the people drinking such water, even to the extent of death from chronic fluorosis, the latest incident of which has been reported in the January 1966 issue of the *Annals of Internal Medicine,* THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association, assembled in Cleveland, Ohio, condemn the addition of fluorine or any other substance to public water supplies for the purpose of affecting the body, or the bodily or mental functions of the consumers, AND BE IT FURTHER

RESOLVED, that copies of this resolution be transmitted to the House of Delegates of the American Medical Association, to the President of the United States, the Members of Congress, the governors of the several states, and the mayors of our principal cities, and released to the media of public information.

(See Resolution No. 24)

INSURANCE FORM
APPROVED BY THE OHIO STATE MEDICAL ASSOCIATION

Date.....

Patient.....Address.....

Diagnosis.....

.....

Report of Services Rendered

Date	Service	Charge	

Date	Service	Charge	

Total $.....

Code for Above Services

OV office visit	PE physical examination	ECG electrocardiogram
HC house call	S surgery	R injection
HV hospital visit	P physiotherapy	L laboratory

Degree of Disability .....

Prognosis .....

Disposition .....

Comments .....

The above report has been read and approved by me.

.....
Patient's signature

....
If not patient — relationship Physician's signature

All charges are based on my usual and customary fee.

RESOLUTION NO. 29

Training More General Practitioners

(By the Huron County Medical Society)

WHEREAS, Richard Meiling, M. D., Dean of Ohio State University College of Medicine, has been quoted in the public press as stating: "I Don't Know What General Practice Is" — *(Cleveland Plain Dealer,* March 13, 1965), and

WHEREAS, Julius Michaelson, M. D., Past President of the Academy of General Practice, has defined a general practitioner (family physician) as a physician — "whose power of diagnosis, in both physical and mental spheres — with respect to all ages and all sexes, in the family structure or individually — are highly attuned; whose knowledge of the total therapeutic armamentarium and the medical structure is acute; and whose practical application of the Art and Science of Medicine in its best sense is highly developed," and

WHEREAS, the American Academy of General Practice is indeed the only medical organization in this Country compelling its membership to maintain high standards by requested yearly postgraduate educational refresher courses, and

WHEREAS, James Z. Appel, M. D., President of the American Medical Association, recommended more emphasis on training of family physicians by medical schools as a way to alleviate the problem of fragmentation of community health services and further stated — "I feel strongly — and in doing so I merely echo the feeling of the majority of my colleagues in medicine — that it is time some of our medical schools get over a rather giddy preoccupation with medical specialty," — (address at meeting of American Association of Public Health Physicians, Chicago, November, 1965), and

WHEREAS, the Ohio State Medical Association — Ohio Academy of General Practice Joint Committee on Family Practice has met personally with Dean Meiling, his staff, and other deans of medical schools of the State of Ohio to present a detailed comprehensive plan for the detailed tentative procedures in attaining such a realistically desirable goal as graduating more family physicians, and

WHEREAS, it is a statistical fact that Ohio communities request family physicians (OSMA Physicians' Placement Service) 15 times more often than specialists, and

WHEREAS, it would be a realistic and functional responsibility of the medical schools in the State of Ohio, in a democratic spirit of supply and demand free enterprise system, to meet the demands (needs) of the citizens of Ohio pertinent to a need of more family physicians; THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association express a most sincere thanks and token of gratitude to the Joint Committee of the Ohio State Medical Association — Ohio Academy of General Practice for their untiring efforts to bring about the fulfillment of the most realistic, dire, and critical need for an increase in the numbers of family physicians in the State of Ohio — and even nationally; BE IT FURTHER

RESOLVED, that Richard Meiling, M. D., Dean of the Ohio State University College of Medicine, be reminded of the meetings with the above joint committee, perhaps by being forwarded a copy of this resolution; AND BE IT FURTHER

RESOLVED, that the suggestions of this resolution be acted upon swiftly and commensurate with the acute and dire critical need for more family physicians, both Statewide and nationally. The latter action being taken wholeheartedly, most diligently, and most sincerely by the various deans of the medical schools in the State of Ohio as a fulfillment of their responsibilities as medical leaders and as has been voiced by the President of the American Medical Association.

RESOLUTION NO. 30

Licensing Foreign Graduates

(By the Delegates of the Summit County Medical Society)

WHEREAS, the Ohio State Medical Board has limited Ohio medical licensure to full citizens of the United States similar to action by 22 other states, and

WHEREAS, the Constitution and By-Laws of the Ohio State Medical Association require that an applicant for membership have an Ohio license, and

WHEREAS, foreign graduates finish residency requirements, obtain permanent visas, file declarations of intent for citizenship and then must wait up to three years before being eligible for licensure and membership, and

WHEREAS, the Ohio State Medical Board is ignoring the practice of medicine in this interim by these men, and county medical societies cannot offer membership with its corollary orientation and discipline during this period, and

WHEREAS, certain hospitals may be illegally employing these physicians for the corporate practice of medicine in emergency rooms, obstetrical services and other disciplines, THEREFORE BE IT

RESOLVED, that the House of Delegates, of the Ohio State Medical Association, request The Council to confer with the Ohio State Medical Board on this threat to the standard of health care in Ohio, AND BE IT FURTHER

RESOLVED, that these conferences take into consideration the following facts:

(1) A significant decrease in the ratio of physicians to population in the metropolitan centers of Ohio is occurring;

(2) Citizenship is not relevant to a man's professional ability or ethics;

(3) State Board examinations (which are already failed by 40.9 per cent of foreign graduates and 1.7 per cent of graduates of U. S. schools nationally) be made sufficiently difficult that the improperly or inadequately trained man would be eliminated on this basis rather than for a reason of ethnic origin;

(4) Help in examining foreign graduates by specialty boards could provide an additional yardstick of ability, which again is more appropriate to the object in mind of licensing only the scientifically qualified applicant;

(5) The public needs the protection that would be afforded by ethical orientation and discipline of these foreign graduates in their first years of practice in this country.

RESOLUTION NO. 31

Procedure for Amendments to the Medical Practice Act of the State of Ohio

(By the Academy of Medicine of Cincinnati)

WHEREAS, the House of Delegates of the Ohio State Medical Association has recommended that action be taken to amend the Medical Practice Act of the State of Ohio; and

WHEREAS, medical inspectors are experiencing difficulty in enforcing the Medical Practice Act in its present form; THEREFORE BE IT

RESOLVED, that The Council of the Ohio State Medical Association be authorized to schedule a conference on the necessary amendments to the Medical Practice Act of the State of Ohio; AND BE IT FURTHER

RESOLVED, that the secretary, executive secretary and legal counsel representing county medical societies be invited to participate in such conference.

RESOLUTION NO. 32

Voluntary Health Insurance

(By the Stark County Medical Society)

PREAMBLE

A direct result of organized medicine's effort to forestall King-Anderson type legislation was the emergence

of a splendid voluntary health insurance industry which extended coverage to persons over 65. Under the Medicare Law, it is legal for persons over 65 not to participate in either part A or B of the government program, there are many people over 65 that do not want to participate if their voluntary health insurance is still available to them.

It is the declared intent of labor to extend the Medicare Law to persons of all ages. If this effort is successful over the American Medical Association's campaign to repeal portions of the Medicare Law, the voluntary health insurance industry and the public will suffer a grievious blow.

Blue Cross Plans in some areas of the country already are announcing that at midnight on June 30, 1966, some contracts for persons 65 or older will be canceled, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association make every effort to encourage the voluntary health insurance industry in Ohio not to cancel contracts but to continue offering improved contracts to persons 65 and older, and these contracts should not be confined to supporting the Medicare Law but should be written to meet the wide variety of needs for persons over 65.

RESOLUTION NO. 33

Industrial Commission Usual and Customary Fee

(By Charles H. McMullen, M. D., Delegate, Ashland County)

WHEREAS, the Industrial Commission of Ohio and the Bureau of Workmen's Compensation have initiated a program of reimbursing physicians their usual and customary fees for professional medical care of Workmen's Compensation cases, and

WHEREAS, this program demonstrates a spirit of cooperation with and confidence in the physicians of Ohio, and

WHEREAS, this usual and customary fee program reflects sound leadership in the administration of the responsibilities of the commission and the bureau, THEREFORE BE IT

RESOLVED, that this House of Delegates of the Ohio State Medical Association officially commends the Industrial Commission of Ohio and the Bureau of Workmen's Compensation for this program, AND BE IT FURTHER

RESOLVED, that the component county medical societies and their members continue to extend their full cooperation and assistance in helping to insure the successful administration of this usual and customary fee program.

RESOLUTION NO. 34

Industrial Commission - Physician Ethical Relationship Concerning Prescriptions

(By the Lorain County Medical Society)

WHEREAS, it is recognized that there be a fundamental respect maintained for attending physician-industrial patient relationship in the best interests of treatment, and

WHEREAS, it is recognized that the attending physician is in the best position to prescribe unusual medications for unusual injuries and industrial sickness, and

WHEREAS, it is also recognized that it is also the privilege of the Industrial Commission to question the rationale of unusual drugs in unusual injuries, and

WHEREAS, it is recognized that notification of disapproval of unusual prescriptions directly to the pharmacist, before notifying attending physician, infers erroneous therapeutic judgment of said physician and casts doubt on said physician's medical ability, THEREFORE BE IT

RESOLVED, that the Industrial Commission be urged to first request explanation of rationale of unusual prescriptions from attending physician to maintain respectful relationship between physician and patient, and between physician and pharmacist, in the best interests of the treatment of industrial patient.

RESOLUTION NO. 35

Aircraft Safety

(By the Academy of Medicine of Cleveland)

WHEREAS, air travel is a major means of transportation today, and

WHEREAS, it is used by nearly all persons, and

WHEREAS, the magnitude of an air crash tragedy is usually proportional to the number of passengers on board, and

WHEREAS, some pilot error and mechanical failure are inevitable, and

WHEREAS, speedy evacuation of still living passengers after a crash is absolutely necessary if their lives are to be saved, THEREFORE BE IT

RESOLVED, that

(1) The Federal Aviation Agency be urged to limit the number of passengers allowed on any one commercial aircraft, and

(2) the minimum seating space per passenger be increased, and

(3) emergency means of egress be improved.

RESOLUTION NO. 36

Public Health

(By the Huron County Medical Society)

WHEREAS, in 1962, we had a national health menace from importations from the Orient, namely contaminated stuffed chicken, and

WHEREAS, apparently the usual appropriate committees of the American Medical Association and the U. S. Public Health Service have failed to endorse, legislate and enforce sufficient laws to prohibit this from recurring in the future as evidenced by subsequent importations, and

WHEREAS, in 1965 we witnessed several examples of material, toys, "ice balls," and trinkets, grossly contaminated, again being freely sold in this country, and

WHEREAS, nothing is done to prevent epidemiological trouble, but rather alarm is spread after the products are imported, and

WHEREAS, many of our population are not immune to these type organisms thus allowing a potential epidemic to exist, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association instruct its Delegates to the AMA to introduce and support a resolution instructing the appropriate committee of the AMA to work with the public health authorities, the port authorities and the Bureau of Customs to insure that the health of the American public is protected from such dangers.

RESOLUTION NO. 37

Health Insurance for Migrant Workers

(By the Huron County Medical Society)

WHEREAS, the State of Ohio imports seasonal migrant workers, and

WHEREAS, medical and hospital care is a continual need for the welfare of said people, and

WHEREAS, more often than not, said people do not carry health insurance, and

WHEREAS, many communities are left with sizeable unpaid hospital and medical bills as the migrant workers leave the communities in which they were temporarily employed, THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct the officers and the staff of the Association to help resolve this problem by meeting with the Blue Cross-Blue Shield representatives; members of the State Department of Health; other health in-

surance agencies; and with representatives of industrial organizations or whatever other sources they might think helpful to solve the problem of adequate health insurance for the migrant workers.

RESOLUTION NO. 38

Traffic Accidents and Medically Incompetent Aged Drivers

(By the Lorain Counuty Medical Society)

WHEREAS, the number of automobiles and traffic have increased by leaps and bounds, and

WHEREAS, the number of aged 65 and older have increased due to medical advances, and

WHEREAS, a good percentage of drivers 65 years and older are affected with the infirmities of age causing vertigo, transient syncope, hazard of a sudden heart attack and cerebral vascular accident, emotional instability, decreased neuromuscular integrity, threat of insulin reactions or diabetic coma due to brittle diabetes, and

WHEREAS, under present system of driver's license renewal, such incompetent aged drivers cannot be denied licensure until said drivers are involved in serious traffic accidents, THEREFORE BE IT

RESOLVED, that everyone reaching age 65 years be required by law to take a driver's test by state patrol or any other officers of the law designated by Highway Department within six months after 65th birthday or within one year if presently over 65 years of age, to evaluate mechanical and judgmental competency to operate a motor vehicle; said examination to determine whether driver's license should be revoked or whether driver should repeat examination every six months, one year, or two years according to judgment of examiner.

RESOLUTION NO. 39

To Upgrade the Education of the Deaf and Hard of Hearing

(By the Fourth District Councilor,

Robert N. Smith, M. D., Toledo)

WHEREAS, the problems of deafness are founded in the loss of auditory communication, and

WHEREAS, these problems can be largely overcome by proper special education, and

WHEREAS, in the 1963 research of the Division of Special Education of the State of Ohio it was estimated that one child in every 20 in school or at the preschool level had a significant hearing loss, and

WHEREAS, only fifteen per cent of today's deaf young people successfully complete the full scale high school academic program, and

WHEREAS, the deaf are conceded to have potentially normal intelligence when tested by standardized nonverbal tests, and

WHEREAS, it is the duty of the physician to promote rehabilitation when he cannot cure; THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association urge that the State Board of Education be instructed by the Governor to upgrade deaf education in the State of Ohio

(a) by promoting oral education of the deaf child in contrast to the manual method;

(b) by providing more educational facilities, properly staffed and equipped, with a goal of one special education unit for the deaf per county, or small group of counties;

(c) by integrating these special education units with regular elementary and high school facilities, where possible;

(d) by constantly recruiting young people to enter the field of Deaf Education as a profession, and

(e) by seeking adequate funds from the legislature to support a proper program; AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association promote a broad public educational program beamed through the Parent-Teacher Associations, Mothers' Club, Child Conservation Leagues and civic organizations for the purpose of urging an improvement in the education of the deaf and hard of hearing in the State of Ohio; AND BE IT FURTHER

RESOLVED, that all physicians, especially those in general practice and the specialities of pediatrics and ear, nose and throat, be adequately prepared to advise their patients as to the scientific techniques and special educational facilities which are available for the education and rehabilitation of the deaf or hard of hearing child or adult.

RESOLUTION NO. 40

Condemning Actions Taken By Many Blue Cross Plans

(By the Huron County Medical Society)

WHEREAS, many state Blue Cross Plans have written letters to their elderly policyholders suggesting that they enroll under Part B, Title 18 of Public Law 89-97 (Medicare Law) and drop their Blue Cross coverage; and

WHEREAS, there seems to be a nationwide concerted action by the various group Blue Cross Plans in conjunction with the Federal Government to coerce these previous elderly policyholders to sign up for Part B of Medicare; and

WHEREAS, in many instances these previous elderly low cost policyholders will be left no alternative but to sign up (like it or not) under the Medicare Law, and

WHEREAS, indeed the private health insurance industry has been a very real positive factor in the attainments of the highest standards of medical care given the American citizen; and

WHEREAS, this may indeed represent the beginning of the federalizing of the private health insurance industry; and

WHEREAS, the Blue Cross of Northwest Ohio most naively and grossly misinformed its policyholders in a recently published pamphlet — to wit — "Medicare Part A (Hospital Insurance Benefits) is automatic — It costs you nothing"; and

WHEREAS, these pamphlets, letters, and radio broadcasts raise a question of conspiracy to force the elderly to enroll under Part B; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association condemn these actions by the various Blue Cross Plans and indeed sincerely acknowledge the fact that the private health insurance industry is destroying a most healthy and beneficial segment of the free enterprise system, which industry had previously rendered a most worthy service in making better plans available to the elderly citizens and at a more competitive price; BE IT FURTHER

RESOLVED, that a copy of this resolution be sent to the various Blue Cross organizations in the state of Ohio.

RESOLUTION NO. 41

Regarding "Forms" for Participants of Part B of Medicare

(By the Huron County Medical Society)

WHEREAS, the filling out of forms and papers for each house call and/or office call for participants of Part B of Medicare would:

(a) limit the choice of physicians to the patient;

(b) impose on the attending physician, most unreasonably, an unsurmountable amount of red tape forms to process and waste a considerable portion of his most valuable and critically short time which he would best be giving to the practice of medicine

rather than to the execution of clerical chores; THEREFORE BE IT

RESOLVED, that insurance and/or hospitalization-like forms be requested only in:

(a) complicated medical cases which would require 10 calls or more for the same disease;

(b) complicated surgical operative procedures; BE IT FURTHER

RESOLVED, that in those cases where forms are to be filled out, the "Insurance Form approved by the Ohio State Medical Association" be accepted by the Department of Health, Education, and Welfare, BE IT FURTHER

RESOLVED, that the physician's signature on this form shall be the equivalent of a receipted bill.

RESOLUTION NO. 42

Defining "Receipted Bill" for Participants of Part B of Medicare

(By the Huron County Medical Society)

WHEREAS, there seems to be an understanding that the Department of Health, Education, and Welfare requests a receipted doctor's bill from participants of Part B of Medicare before it will refund monies to said participants, and

WHEREAS, a bill cannot be receipted until paid, and

WHEREAS, this request is unreasonable and not in keeping with the intent and/or spirit of the Medicare Law — THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association submit to the Department of Health, Education, and Welfare that a signed statement from the attending physician to his participating patients of Part B of Medicare shall be honored as a receipted bill.

RESOLUTION NO. 43

Direct Billing

(By the Huron County Medical Society)

WHEREAS, it is the accepted practice of the majority of health insurance carriers to reimburse their insurees specified sums on a contractual-agreement basis for specified services purchased; and

WHEREAS, no such contract exists under Part B of Medicare between potential patients and the Federal Government; and

WHEREAS, acceptance of assignments from Medicare patients would constitute an agreement by physicians to accept tax funds in any amount the government carrier might decide fitting and would waive recourse to the patient for a possible balance of the physician's fees; and

WHEREAS, the Department of Health, Education, and Welfare, through Mr. Wilbur Cohen, has previously indeed favorably suggested that doctors continue the practice of direct patient billing; THEREFORE BE IT

RESOLVED, that any physician rendering services to any patient under the Medicare Law continue direct billing to the patient, rendering an itemized statement, and said patient consider it his responsibility to pay same bill — using funds from whatever sources might be available to him — Medicare or other; BE IT FURTHER

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct the staff of the Ohio State Medical Association to make a special effort to inform each member of the Ohio State Medical Association of this resolution, if adopted; BE IT FURTHER

RESOLVED, that the Ohio State Medical Association inform the Department of Health, Education, and Welfare of the contents of this resolution, thereby conveying the terms ethically necessary for the physicians of the state of Ohio to participate in Medicare.

The Association and The Journal Have New Columbus Address

After some 35 years in the same building, the Ohio State Medical Association's headquarters offices have moved to a new address in downtown Columbus.

With completely remodeled facilities in the landmark Huntington National Bank Building, the new mailing address is:

The Ohio State Medical Association
17 South High Street - Suite 500
Columbus, Ohio 43215

The Journal occupies a part of this same suite and should be addressed as follows:

The Ohio State Medical Journal
17 South High Street - Suite 500
Columbus, Ohio 43215

New telephone number for both offices is 228-6971 (Area Code 614). Entrance to the new quarters is just a few steps south from Broad and High Streets, traditional center of activity in Ohio's capital city, facing the Statehouse grounds from the West. The former offices of the Association and *The Journal* were at 79 East State Street, also in the downtown Columbus area.

RESOLUTION NO. 44

Medical Ethics

(By the Huron County Medical Society)

WHEREAS, the mission and prime purpose of a physician is to serve the common good and improve the health of mankind, and

WHEREAS, the prime object of the medical profession is to render service to humanity, and

WHEREAS, doctors are trustees of medical knowledge and skill and must dispense the benefits of their special attainments in medicine to ALL who need them, and

WHEREAS, physicians dedicate their lives to the alleviation of suffering, to the enhancement and prolongation of life, and to the destinies of humanity, and

WHEREAS, the above are principles of medical ethics of the American Medical Association and have been the guiding ethics of physicians for millennia; and

WHEREAS, the Department of Health, Education, and Welfare, through the Ohio State Department of Health, in essence, has made a mockery of the above principles by requesting the physicians of the State of Ohio to stamp a nondiscrimination legend on the statements of welfare patients; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association convey to the Department of Health, Education, and Welfare and the Ohio Department of Public Welfare that the stamping of this legend on the statements of the Welfare category patients is futile, contrary to high standards of Medical Ethics, self-defeating, and not indicative of the accomplishment of anything worthwhile, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association suggest strongly to both departments, in the interest of better serving our patients, that said stamping procedure be discontinued.

Policy Regarding Governmental Medical Care Programs

IN A RECENT MAILING to members of the Ohio State Medical Association, three documents of vital interest regarding governmental agency-hospital-physician relationships were included with a covering letter from OSMA President Henry A. Crawford. The letter and documents follow:

Special Medicare Newsletter No. 3

Dear Doctor:

Included in this letter are the following items:

(1) Jolicy Statement of The Council of the Ohio State Medical Association Regarding Government Medical Care Programs.

(2) A highly informative statement, "Composition and Duties of Hospital Utilization Review Committees," prepared by George W. Petznick, M.D., Shaker Heights, an AMA representative on Technical Advisory Committee No. 2 — Physician Participation, one of the committees advising the Department of Health, Education, and Welfare as to rules, regulations, and policies for Medicare.

(3) An opinion of the Chief of the Legal Section, Bureau of Workmen's Compensation, Ohio Industrial Commission, stating that the Commission and the Bureau should not make any payments to a hospital where it is known that there is a fee-splitting arrangement between the hospital and a roentgenologist.

Personally, and on behalf of The Council, I urge you to study this material carefully and to file it for future reference. I am firmly convinced that, if all physicians follow the principles stated in the following presentation, our present system of medical care can be preserved.

If we do not follow the principles established by and for our profession, then they become nothing more than words written on a piece of paper.

Sincerely,

(Signed) Henry A. Crawford, M.D., President
Ohio State Medical Association

Policy Statement of The Council of OSMA Regarding Government Medical Care Programs

INASMUCH AS government has announced that it has assumed, under Public Law 89-97, responsibility for financing the medical care of certain segments of the population, The Council of the Ohio State Medical Association has adopted certain policies for the information and guidance of its members.

For emphasis, reference is made to Title XVIII-Health Insurance Benefits for the Aged, and Title XIX-Grants to States for Medical Assistance Programs.

It is recommended and urged that every physician follow these policies in the conduct of his individual practice of medicine.

Policies Recommended for Individual Physicians

Once the physician accepts a person as his patient, regardless of what third party might be involved, the physician's primary and sole obligation, his contract and his relationship are with the patient.

Any arrangement between government and a citizen whereby the government agrees to pay for the citizen's medical care does not, directly or indirectly, or by inference, involve the physician in a contract with the government.

The physician will continue, even as before, to provide those persons he accepts as patients the best possible medical care at his command.

The physician is requested and urged to deal directly and only with the patient, both in providing medical care and in billing for just and reasonable compensation for the medical care provided.

It is recommended, inasmuch as the agreement for financial responsibility is between the patient and the government, that the physician not accept any assignment form.

It is recommended, in accordance with the Principles of Medical Ethics and the Statutes of Ohio regarding corporate practice of medicine, that each and every member of this Association submit to the patient his own bill and receive on his own behalf, compensation for his professional medical services.

It is the official policy of this Association that every physician bill and receive for his professional medical

services his usual, customary, and reasonable fee. "Usual, customary, and reasonable fee" is defined as follows:

Usual — The "usual" fee is that fee usually charged for a specific service provided by an individual physician for his patient.

Customary—A fee is "customary" when it properly reflects the extent and nature of the services provided the patient.

Reasonable — A fee is "reasonable" when it meets the "usual and customary" criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration.

In cases where review or mediation may be requested, it is recommended that the standard mediation or review mechanism of the county medical society be utilized. Further, it is recommended that no special review or mediation committee be appointed solely to handle cases involving Public Law 89-97.

Requirement of Pledges or Statements Objectionable

The Profession finds objectionable and distasteful any regulation or requirement that a physician sign pledges or produce statements that he will abide or has abided by the laws in providing his professional services. Such requirement or regulation is, of itself, an act of discrimination against the profession, and is degrading.

The propriety of the conduct of members of this Association is determined by the Principles of Medical Ethics, to which all members of this Association willingly and freely pledge themselves.

For emphasis, reference is made specifically to Section 4 of the Principles of Medical Ethics:

> "Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. **Physicians should observe all laws,** uphold the dignity and honor of the profession and accept its **self-imposed** disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

ADOPTED BY THE COUNCIL OF THE
OHIO STATE MEDICAL ASSOCIATION
MARCH 20, 1966

A Statement on: Composition and Duties of Hospital Utilization Review Committees

By GEORGE W. PETZNICK, M.D., Shaker Heights

Member, Representing AMA, of HEW Technical Advisory Committee No. 2 — Physician Participation; Past President, OSMA, and Member of Ohio Delegation to AMA House of Delegates

IF YOUR HOSPITAL expects reimbursement from the fiscal agent of the government for "Medicare" patients, then the medical staff of your hospital is required to have a utilization review committee.

If you have a utilization review committee in your hospital, it is necessary for your hospital to indicate that such a committee is functioning to the Ohio State Director of Health. The director will then certify to the government (HEW) that your hospital has qualified to be reimbursed for "Medicare" patients.

Further, all accredited hospitals are required to have functioning utilization committees.

There is no stereotype form required for any utilization review committee and, if your hospital staff decides on a committee that will serve the purpose in your hospital, stay with it and insist that this is the form of utilization that best serves the purposes for your patients, their medical care and your hospital.

Not "Claims" Review

There is much confusion among many physicians, hospitals, and fiscal agents when the term "utilization" is used. This is because the fiscal agents (Blue Cross, voluntary and private insurers and labor unions) think in terms of "claims" review. Such "claims" reviews are not now and should not be the function of a hospital review committee; rather they are administrative.

The real purpose of utilization review committees is solely educational for a given medical staff in a given hospital and controlled by the members of the

medical staff. It is not impossible for a hospital medical staff utilization committee to, unknowingly, be used for "utilization claims" review when hospital administrative activities become involved.

Publications Listed

There has been much written and many people have discussed utilization review plans but may I suggest a few important publications that will help to guide anyone who is interested in such activities.

1 — The "Marshall Plan" of Pittsburgh — probably one of the first well-organized utilization plans in this country.

2 — The AMA pamphlet "Utilization Review," a handbook for the medical staff that was written by the Council on Medical Service.

3 — "Conditions of Participation for Hospitals"— printed by the Department of Health, Education, and Welfare.

4 — "AMA Advisory Committee's Report No. 9" — published by the AMA.

5 — "AMA Advisory Committee's Report No. 10" — published by the AMA.

6 — "Medical Economics" — Feb. 21, 1966, issue.

Medical utilization review committees are comparatively new. However, it will be your committee, not the government's, and it should be a function of your medical staff and not the hospital administrative staff.

Good and purposeful medical review committees can be and are educational to many physicians and much good can be accomplished in health care by an efficient, effective medically controlled and medically-staffed committee.

In conclusion, it cannot be emphasized too strongly that the official policy of the American Medical Association and the Ohio State Medical Association is this: "Hospital utilization review committees **shall** be composed of practicing physicians."

Opinion of Chief, Legal Section, Bureau of Workmen's Compensation Inter-Office Communication

Date: March 7, 1966

To: Dr. Raymond B. Hudson, Chief Deputy Administrator, MEDICAL SECTION

From: Thomas E. Brock, Chief Deputy Administrator, Legal Section

You have requested my opinion on the question of whether or not the Industrial Commission of Ohio and the Bureau of Workmen's Compensation can pay for x-rays taken by a roentgenologist where said payment is collected by the hospital and in turn is paid in whole or in part to the roentgenologist.

1. Section 1701.03 R.C. prohibits the practice of a profession by a lay-corporation or association of any type.
2. These entities cannot do indirectly what is prohibited by statute, namely, through the hiring of a licensed physician.
3. There is no legal duty placed upon the Industrial Commission of Ohio or the Bureau of Workmen's Compensation to ascertain initially whether a corporation or an association mentioned above is practicing medicine.
4. No state department such as the Industrial Commission of Ohio or the Bureau of Workmen's Compensation should subscribe, aid or abet knowingly in any illegal practice or in any violation of a code of ethics adopted by a professional body for the public good.

Therefore it is my opinion that the Industrial Commission of Ohio and the Bureau of Workmen's Compensation should not make any payments to a hospital where it knows that there is a fee splitting arrangement between the hospital and a roentgenologist.

This opinion does not apply where a charge is made (by the hospital solely) for the use of equipment or space.

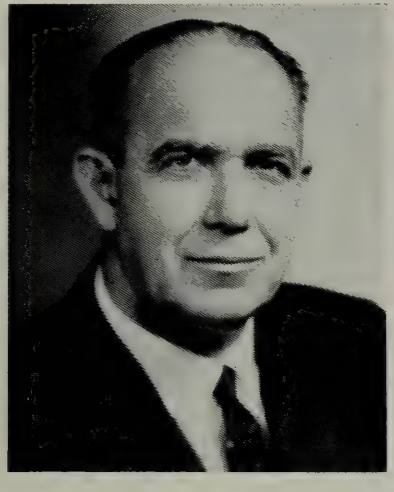
(Signed) Thomas E. Brock
Chief Deputy Administrator
Legal Section

Candidates for the Office of President-Elect of OSMA

UNDER revised Section 1 (a) of the OSMA Bylaws, the following names of candidates for the office of President-Elect have been filed with the Executive Secretary 60 days prior to the meeting of the House of Delegates at which the election is scheduled to take place, that is on May 27, during the 1966 Annual Meeting of the OSMA in Cleveland:

ROBERT E. HOWARD, M. D.
Cincinnati, Ohio

Dr. Robert E. Howard who is nominated for President-Elect of the Ohio State Medical Association for 1966-67, has served as Councilor of the First District of the OSMA from 1962-66. Dr. Howard has also served for the Academy of Medicine of Cincinnati as Trustee, Secretary-Treasurer and its 103rd President. He has been President of the Cincinnati Medical-Dental-Hospital Bureau and the Cincinnati Speech



and Hearing Center. His Pre-medical studies were taken at Ohio Wesleyan University and he graduated with four degrees from the University of Cincinnati in 1925, 1926, 1927, and 1928. Dr. Howard is Associate Professor of Otolaryngology at the University of Cincinnati and lectures in Otology and the Clinical Anatomy of the Head and Neck. He is First Grand Vice-President of the International Alpha Kappa Kappa Medical Fraternity.

Dr. Howard is a certified board member of the American Board of Otolaryngology, practicing in a partnership and serving on the staffs of nine Cincinnati hospitals.

During the last year he has been chairman of two important committees of the OSMA — the Medical Advisory Committee for the Ohio State Society of Medical Assistants, and chairman of the OSMA's Auditing and Appropriations Committee.

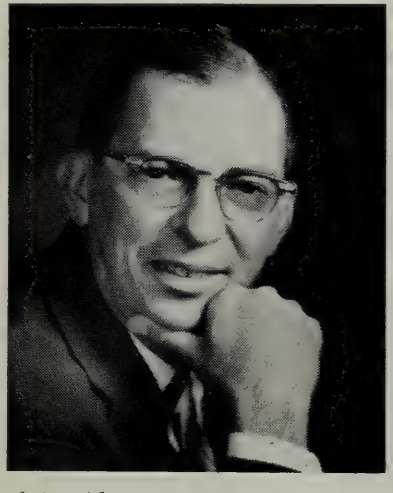
He has three sons and a daughter, and his wife Betty is a graduate nurse from Bethesda School of Nursing in Cincinnati.

His greatest concern is the continuance of the high quality of medical care, in spite of the invasion and threatening control of medicine by Federal and State Departments of Health, Education and Welfare, and the future Government so-called "Social Progress Program."

BENJAMIN C. DIEFENBACH, M. D.
Martins Ferry, Ohio

Dr. Benjamin C. Diefenbach, who is nominated for President-Elect of the Ohio State Medical Association, was born in Bluffton, Indiana, November 2, 1911, the second son of Howard Berleman and Josephine Zartman Diefenbach. His maternal grandfather was a clergyman, as was his father.

His grade school education was quite scattered because of the travels of his father. He graduated from



grade school in Akron in 1925 and graduated from West High School, Akron, in 1929. He received an A.B. degree from Heidelberg College, Tiffin, Ohio, in 1933 and received his M.D. degree from Western Reserve University School of Medicine in 1937.

Dr. Diefenbach interned at Akron City Hospital on a rotating service. He was House Doctor at Martins Ferry Hospital for approximately 18 months and has been in family practice in Martins Ferry since.

He was president of the Belmont County Medical Society in 1956 and has been a member of the OSMA House of Delegates ever since. He has served on the Rural Health Committee and has been Councilor for the Seventh District, Ohio State Medical Association, since 1960.

The House of Delegates of the Ohio State Medical Association will meet twice during the OSMA Annual Meeting. The first session is on Tuesday evening, May 24, beginning with a dinner at 6:00 P. M. Refer to the April issue of *The Journal,* page 354, for the agenda of this meeting, including presentation of Resolutions. Resolutions Committees will meet on Wednesday, May 25, and, if necessary, on Thursday, May 26, to hear discussions on Resolutions presented. Final House session is on Friday, May 27, at 9:00 A. M. Refer to April issue, page 363.

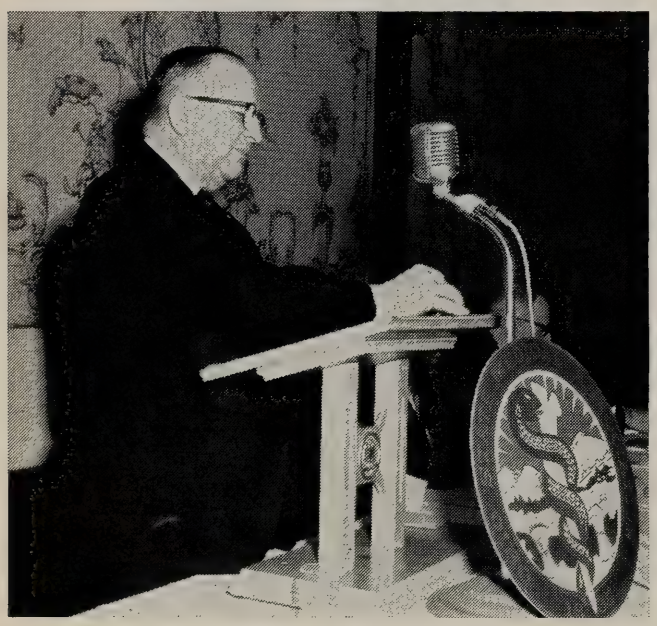
Medical Society Officers' Conference . . .

OSMA Is Host in Columbus to County Officers and Committeemen For a Discussion of Matters of Vital Interest to the Profession

THE Annual County Medical Society Officers Conference, held in Columbus on Sunday, February 27, was well attended, with 196 persons registered and 185 in attendance at the luncheon. All Eleven Councilor Districts were well represented, with the Tenth District having a total attendance of 29. Persons were present in some official capacity from 75 per cent of Ohio's 88 County Medical Societies. The meeting was held in the Pick-Fort Hayes Hotel in downtown Columbus, where luncheon was served with the compliments of the Ohio State Medical Association.

Morning Session

Dr. Henry A. Crawford, President of the Ohio State Medical Association, gave the keynote address of the conference which centered around a discussion of the medical profession's responses to the impact of various governmental programs upon hospitalization and the practice of medicine. Dr. Crawford presided during the remainder of the morning session.



Dr. William R. Schultz, Wooster, Councilor of the Eleventh District of the OSMA, and chairman of the OSMA Committee on Hospital Relations, spoke on the topic "The Physician and Hospital Relations."

Dr. Schultz discussed the increasing concern of the medical profession over the encroachments of hospitals into the practice of medicine, and stressed the need of alertness on the part of medical staffs to draw definite lines between responsibilities of physicians and those of hospital personnel. He further urged that members of medical staffs maintain close liaison with administrators and hospital trustees.

In regard to the Medicare program, Dr. Schultz described the various problems that face the medical profession in regard to physician-hospital relationships under the plan to become effective July 1.



Dr. William H. Holloway, Akron, a member of the OSMA Committee on Mental Health, and former secretary-treasurer of the Summit County Medical Society, discussed the responsibilities, relationships and goals of the County Medical Society in regard to community and areawide mental health planning and development.





Dr. John H. Budd, Cleveland, chairman of the Ohio Delegation to the American Medical Association, spoke on the topic "OSMA Delegation Activities at the 1965 AMA Clinical Convention." A report on the AMA Convention and highlights of Ohio's part in proceedings was published in the January issue of *The Journal,* beginning on page 58.

Dr. Budd described in more detail the actions of Ohio Delegates in Philadelphia and some practical aspects of the AMA House of Delegates in action.



Hart F. Page, Executive Secretary of the OSMA, explained "Congressional Redistricting and Legislative Reapportionment in Ohio," and told the audience what reapportionment might mean in the Ohio General Assembly as far as its outlook on medical and health legislation is concerned. Mr. Page also emphasized the need for continuing liaison between county medical societies and members of the Ohio General Assembly.

Councilor District Conferences

An important part of the day's activities was the time devoted to individual conferences of the 11 Districts. Each District conference was presided over by the Councilor and discussions were held on matters of particular interest locally.

A luncheon, compliments of the Ohio State Medical Association, was served in the Regency Ballroom of the Pick-Fort Hayes Hotel.



Dr. Hudson Addresses Group

One of the highlights of the conference was a talk by Dr. Charles L. Hudson, Cleveland, President-Elect of the American Medical Association, whose topic was "The American Medical Association in 1966."

Dr. Hudson, who will be installed as President of the AMA at the June Annual Convention in Chicago, described the AMA's goals and projects for the coming year, drawing on the background of information he has accumulated in his present office and as former member of the AMA Board of Trustees.



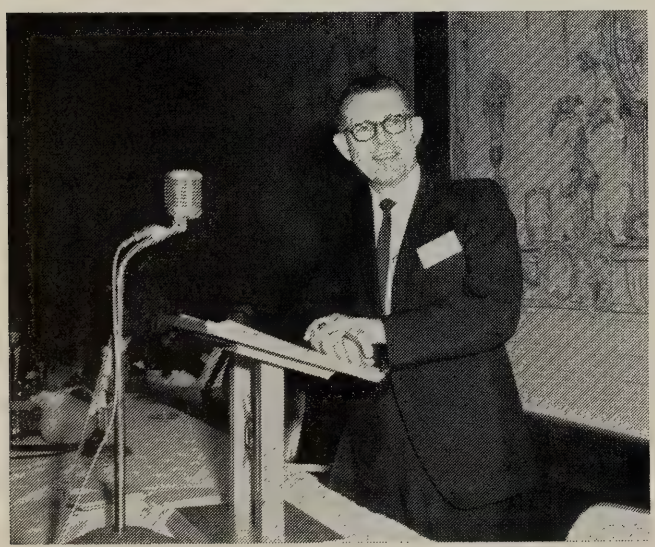
Dr. Henry P. Worstell, chairman of the OSMA Committee on Workmen's Compensation, discussed "The Workmen's Compensation Usual and Customary Fee Plan." The Industrial Commission and the Bureau of Workmen's Compensation changed

from a fixed fee schedule to the "usual and customary fee" basis last October, after long negotiations on the part of the State Association.

Dr. Worstell explained that the "usual and customary fee" is the fee that the individual doctors usually charges his private patients for the service indicated. More than 99 per cent of Ohio physicians are cooperating with the state agency in charging their "usual and customary fee" for services performed for Ohio workers, the speaker declared.



Dr. Drew L. Davies, Columbus, chairman of the OSMA Military Advisory Committee, spoke on the topic, "The Doctor Draft and the County Military Advisory Chairman." He discussed the alarming drain on Ohio physicians because of the Vietnam conflict, but pointed out that Selective Service has cooperated with state and local military advisory committees in calling doctors to active service. He urged local committees to function realistically so that this cooperation will continue.



Presiding at the afternoon session was Dr. Lawrence E. Meredith, Elyria, President-Elect of the State Association.



Dr. Frank H. Mayfield, Cincinnati, Past President of OSMA, and chairman of OMPAC, gave a progress report on the Ohio Medical Political Action Committee. Dr. Mayfield urged support of this program whose purpose is to help elect persons to Congress who will consider the medical profession's viewpoint when national legislation is before the lawmakers.

There has been a substantial upsurge in membership, Dr. Mayfield pointed out, but there is need for much more support, especially in view of Ohio's growing importance as a major battleground in the coming Congressional elections.



Dr. Samuel Saslaw, Columbus, chairman of the OSMA Committee on Scientific Work, gave some highlights of the coming OSMA Annual Meeting in Cleveland, May 24-28, and urged county officers and committeemen to promote interest in the meeting in every way possible.

"Contract Practice" — A Large Project

By S. H. MOUNTCASTLE, Executive Secretary
Summit County Medical Society

IN A MODERN SENSE, the project aiming at the ultimate observance of the fee-for-service principle in all contracts signed by Summit County, Ohio, physicians for the provision of their professional services had its beginning in June, 1963, in the actions of a combined meeting of hospital-based specialists. This meeting was called by the county medical society's **Committee on Medical Economics and Contract Practice** after a local pathologist had asked for a resolution to separate payments for laboratory services from Blue Cross contracts.

More historically, endorsement and implementation of the fee-for-service principle in just **hospital** contracts dates back to a statement adopted by the general membership meeting in 1953. This was on the occasion of one hospital demanding a salary relationship in pathology. Then in, 1958, with the United Mine Workers moving toward panel practice, action extending the concept to other medical service contracts and contractors in addition to hospitals was taken by the general membership meeting. This led to the formation that year as part of the Medical Economics Committee of the so-called "**Contract Practice**" Committee of the Society mentioned first above.

Background of Committee

Although this committee's functions were to determine if the Principles of Medical Ethics were observed in contract practice, the Committee on Professional Ethics as such was maintained separately and retained the disciplinary functions.

The new "contract practice" responsibility being tied to the old Medical Economics Committee demonstrates that, initially, contract practice was looked upon more as a problem of medical care distribution and prepayment economics than as a matter of ethics and, later, of law.

Continuing the evolutionary basis for the current activities and concepts in this committee, it is noteworthy that the jurisdiction was again enlarged in 1963 — this time to include contracts between **corporations of physicians** and physicians. Such a contract was referred and found to be unethical in December of that year — providing as it were for fee splitting and restraints on free choice of physician. The committee's decision was "checked" at its request by the Judicial Council of the American Medical Association, confirmed as correct, and the members concerned complied. Further reflecting its dual role, however, as a Committee on Medical Economics, the contract practice body concurrently handled development of a statement reaffirming the Society's adherence to the indemnity principle in the field of prepayment plans. This was germane to labor negotiations in the rubber industry in process at the time.

By the spring of 1964, this committee was again enlarged in perspective and assignment by receiving for review the first new contract offered by a corporation of physicians formed for arranging hospital emergency room staffing on an hourly wage basis. This contract eventually was approved. It is noteworthy that still no specific review of a contract in radiology or pathology had been done by the committee although a year had passed since these specialists had demanded full recognition as physicians, governed by the universal Principles of Medical Ethics. This, in turn, is a third reflection of the slow, cautious and at times "trial and error" approach being intentionally and wisely made by the new committee.

Field of Investigation

The Council of the Society, in August of 1964, encouraged the committee to investigate hospital contracts of specific members in cardiology, neurology, radiology, medical education and two more emergency room plans. Concurrently again, the committee was involved in further pressures from rubber negotiations, and it was not until October, 1964, that, as a preparation for its new work, discussions were scheduled with each of the five medical executive committees of the staffs in local hospitals by the committee chairman. The extensive research and development of the guidelines done for those presentations

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About the Author . . .

S. H. Mountcastle has served the Summit County Medical Society as executive secretary since January, 1958. A graduate of Kent State University with an A. B. in public relations, his major academic studies were in economics, the social sciences and journalism.

provided the cornerstone of knowledge and appreciation for all that was to follow.

One very important by-product came out of these staff sessions that was to be the basis in turn for **implementing** the Society's position in the months ahead. I refer here to the suggestion adopted by the Council of the Society that, starting January 1, 1965, **every membership application must include an answer as to whether or not a physician was engaged in contract practice.** The statement incorporated on the application form for membership was as follows:

> "Do you have any contractual arrangements, expressed or implied, for the provision of your professional services with any hospital, corporation of physicians, corporation of laymen or lay body by whatever name called? (If so, please submit a copy and/or terms of such contract with this application.)

Society activity in this field always had been fully publicized and was well known to the membership and hospital officials. It was repeatedly emphasized that reinstatement of the fee-for-service principle, free choice of physician and free competition among physicians to the long-run benefit of good patient care was the object of the effort.

Early in 1965, this general knowledge led to a written request from a group representing 48 members for specific investigation of a contract scheduled for consummation with a new head-of-department in pathology at a local hospital. This particular contract has, of this writing, not been implemented and has not been reviewed in that the department head concerned will not arrive until mid 1966 and has not yet applied for membership.

We will leave entirely for the remainder of this discussion the committee's activities in the field of medical economics and comment only on its contract practice ethics activity beginning with January 1, 1965. It did seem important, however, to establish first that this group, concerned as it was now with medical ethics, was related initially to material questions involved in economic issues and thus avoided the "ivory tower" image.

Number of Applicants

Between January 1, 1965, and March 15, 1966, 62 applicants for membership were presented to the Credentials Committee of the Summit County Medical Society, requiring an answer to the question on contract medicine.

These included applications not only of new associate members applying for the first time, but also the applications of those men completing their year of associate membership and applying for full active membership status. Of these 62 applicants, 17 reported that they had contracts for the provision and/or resale of their professional services.

Three of the 17 were for full-time work at state mental institutions, and the committee tabled action on these applications for the time being, recommending that the Credentials Committee proceed with membership while laws establishing these situations were studied. Two contracts involved, once again, a corporation of physicians as one party and new, probationary members as the second party. Action was deferred until these men applied for active membership in June, 1966, group practice contracts being scheduled with a later priority. The other 12 were handled as follows:

One contract was approved in the EKG and EEG concession field with suggestions for billing process changes that could be brought about with the hospital; one, establishing a hospital in the emergency room business, was completely unacceptable and membership was denied the participant. This contract then was rewritten by a committee of the medical staff involved to meet the committee's requirements, the hospital accepted, and membership was granted. Another emergency room contract developed on the basis of decisions in the foregoing troublesome case was approved.

Two hospital straight-salary employees for general duty were denied membership entirely. The hospital still employs these men and calls them "fellows."

One additional man refused membership offered conditionally to changing his contract. Finally, in the other eight cases, all of hospital employment in radiology and pathology, the committee found the contracts unacceptable in relation to the Principles. In these instances it was duly noted that an entire department of physicians was involved in the unethical situation tied to a basic contract. It seemed unfair to deny the new physician probationary membership and to do nothing about the basic, department-wide problem. Therefore, conditional membership was granted pending department-wide solution by July 1, 1966, and education was begun.

The Broader View

To digress, it is important to note that in these very months when these cases accumulated, action unfolded in the College of American Pathology, the American College of Radiology and the House of Delegates of the American Medical Association which greatly reinforced the position of the county medical society and this particular committee in interesting further the hospital-based specialists. More important, it encouraged the specialists themselves to rectify their agreements and hospital relationships, as partners with the Society — as indeed they most always have been.

It is common knowledge that both colleges acted in September and October, 1965, to require disentanglement by their members from salary and percentage arrangements with hospitals. Concurrently, the AMA House called on these physicians in October, 1965, "to rejoin the mainstream of American medicine," as it was phrased by Wallace D. Buchanan, M. D.,

radiology college president during an Akron address in October.

The combination of these actions of bringing Dr. Buchanan to town and, later, a leader from the American College of Pathology, along with the realization that it would be discriminatory "to treat the symptoms and ignore the disease" led to the decision on the following policy with these eight cases:

1. Meetings to educate the 40 men directly and indirectly involved to the principles concerned and to ways and means of separate billing, separate receiving, leasing, etc. These meetings were conducted on November 24, December 15 and January 12.

2. To establish the date of July 1, 1966, for the installation of ethical contracts in both departments of all five (local) hospitals or to show cause why action should not be taken by the Society.

3. To give the eight young men associate membership. This appeared fair to everyone.

The reader can readily observe implications to industrial medical practice as well as to group medical practice from the activity centering just now on hospital-based contract practice. Already, and in two instances, the committee has had submitted to it (voluntarily) local physicians' contracts with nursing homes. In both of these cases, the contracts were found to be unacceptable and, after extended work together, were rewritten to conform to the Principles of Medical Ethics.

One case involving a group practice has just resulted in an applicant being placed on notice that his contract will not be acceptable after July 1, 1966 but, again, probationary membership was granted on the condition of rectifying it. The assistance of the committee will be given in drafting the new plan as usual — tapping for consultations OSMA, AMA and legal resource people as necessary.

Industrial Medicine Group

To return to the industrial medicine group, no contract review has taken place in this field to date. The beginnings of this are demonstrated, however, by an offer of cooperation and an indication from at least one senior member in that specialty that he would like the advice and counsel of the committee in the near future. This, like the nursing home reviews requested and current initiative by radiologists establishing separate billing particularly, illustrates an encouraging sign of enthusiasm for this effort by the men in contract medicine themselves. The success of the program depends entirely on this factor in the long run.

It is important to observe that an arbitrary review of the roster of active members in this Society of approximately 500 men indicates 197 who are probably, if not definitely, contracting for one percentage or another of their professional services. All of these men will be informed by the county committee of the rules, and of the **wisdom** of the rules, governing contract practice as time goes on. It is the opinion of the present Council of the Summit County Medical Society that this project, aimed at a return to more strict observance of the laws constituting the professionalism of medicine, must be continued. Such opinion has now received major support from the legal and ethical review distributed by the President of the Ohio State Medical Association and prepared by the legal counsel of the OSMA in February. There is evidence that the House of Delegates, OSMA, also will express itself in favor of this kind of program for all counties when it convenes May 24.

The chairman of the committee in Summit County is Dr. James W. Parks whose field of practice is orthopaedic surgery. Dr. Parks has been a member of the Council of the county medical society and a delegate to the House of Delegates, OSMA, since 1962. The members of his committee are: U. T. Jensen, M. D., internist; R. M. Lemmon, M. D., general practitioner and a past president; F. W. Crocker, M. D., pediatrician; D. M. Evans, M. D., surgeon; R. G. McCready, M. D., urologist and a past president; and D. W. Mathias, M. D., ophthalmologist and current SCMS secretary.

They will take as the basis for their May and June discussions of the two deferred contract reviews in group practice the following AMA actions on group practice. The time each committee member has devoted to studying such rulings has given him a new kind of "medical specialty." Here's what the AMA has had to say about groups hiring physicians according to the committee:

PRINCIPLES APPLY TO MEMBERS OF GROUP OR PARTNERSHIP

The ethical principles controlling group practice are the same as for the individual. Since the principles of ethics for private practice absolutely forbid the splitting of fees under any and all circumstances, the same rule applies to group practice and the group formed must be a real partnership in which the total income is divided **not** equally but according to the individual income earned by the member. *(House of Delegates, AMA, 1947)*

CLINIC

The Principles of Medical Ethics are themselves the criteria by which the ethical nature of professional conduct is determined. In connection with any definition of the word "clinic," it should be clear that regardless of how clinic is defined each physician-member of the clinic must act, in his relations with his patients and his colleagues, in accord with all the Principles of Medical Ethics. No physician member of a clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics.

Under the ethical principles of medicine no use may properly be made of the word clinic that

would mislead or deceive the public, or would tend to be a solicitation of patients to the particular group of physicians holding themselves out as a "clinic." *(Judicial Council, AMA, 1957)*

GROUPS AND CLINICS

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession. *(Principles of Medical Ethics, 1955 edition, Chapter I, Section 3)*

DIVISION OF INCOME BY MEMBERS OF A GROUP

The 1946 report of the Judicial Council states, in part, that "The division of income given to members of a group practicing jointly or in a partnership must be in proportion to the value of the services contributed by each individual participant." The 1947 report of the Council states, "Since the principles of eithics for private practice absolutely forbid the splitting of fees under any and all circumstances, the same rule applies to group practice; and the group formed must be a real partnership in which the total income is divided not equally but according to the individual income earned by the member."

In order to clarify its position with respect to the division of group or partnership income the Judicial Council approves and publishes the following rephrasing of its 1946 and 1947 reports on this subject:

The division of income among members of a group, practicing jointly or in partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group. *(Judicial Council, 1959)*

* * *

Contract Practice — voluntary and compulsory adjudication — a delicate balance of both. It's working — but for how long? Reaction is present from hospitals who want reference to society membership taken out of staff by-laws. They say this is illegal, based on certain court decisions elsewhere. There have been none in Ohio. The Society proposes "requiring certification by the society." This is legal. Trustees seem to agree. Comments by Joint Commission inspectors, far from the front lines of current private enterprise medicine and its problems, consciously or unconsciously fan the flames with typical academic ignorance.

Insurance companies could be upset by split bills, social and personal pressures, dig in their heels and refuse direct billing payments. Hospital management, JCAH, insurance companies, an unfriendly public press — all or any could destroy the delicate balance. Yet, all could gain a great deal by befriending this honest effort for integrity, and some are showing that they're wise enough, equally dedicated and understanding. If nothing else, even if the precipitous plunge into inflationary third party medicine cannot be reversed and the diving doctors and contractors brought back up, it seems the plunge can be checked. It certainly is fair to assume, at worst, that new contracts will be approached with new insight and caution by all everywhere.

As always, it takes action, dedication and sacrifice at the county level, but outsiders think county societies are ridiculous unless they can point to state and national policies and actions of similar intent. Neither is lacking in the case of contract practice.

Maternal and Child Care Conference Scheduled in San Francisco

A National Conference on Infant Mortality is being sponsored by the American Medical Association's Committee on Maternal and Child Care on August 12-13 at the Fairmont Hotel in San Francisco, California.

An open invitation to attend is being extended to chairmen and members of all state and county Maternal and Child Care; Perinatal and Maternal Mortality Committees; State Health Department Directors of Maternal and Child Health; medical school faculty members in Departments of Obstetrics and Gynecology, Pediatrics, and Preventive Medicine. Other interested physicians and representatives of groups concerned with the problems of infant mortality are also invited to attend.

Those interested in receiving further information about registration for the Conference should write the Secretary, Committee on Maternal and Child Care, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Clement F. St. John, vice president of University of Cincinnati and director of the university's medical center, has been named president-elect of the Ohio State University Medical Alumni Association.

Dr. G. Adolph Ackerman, associate professor of anatomy in the Ohio State University College of Medicine, presented a paper during a symposium on "The Lymphocyte in Immunology and Haemopoiesis" April 13-16 in Bristol, England. The symposium was sponsored by the department of anatomy of the Medical School at Bristol.

The Ohio State Surgical Association presents . . .

"MEDICARE: ANOTHER VIEWPOINT"

— by THOMAS L. DWYER, M.D.
Mexico, Missouri
President
Association of American
Physicians and Surgeons

THURSDAY, MAY 26th
CLEVELAND

Dr. Dwyer will speak at a banquet in the Cleveland Room of the Sheraton Cleveland Hotel which is open to non-members of OSSA by pre-registration. Dr. Dwyer's appearance is the Association's contribution to the combined medical meeting idea actively sought by OSMA. We regret that Dr. James Z. Appel, President of the American Medical Association, could not appear on the program with Dr. Dwyer, but we have announced to our membership that the earlier talk by Dr. Charles L. Hudson, President-Elect of the AMA, on "Medicare's Rules and Regulations and Their Effect on the Practice of Medicine," as well as the Friday speech by Dr. Edward R. Annis, Past President of AMA, on "Care of the Patient, 1966," should be considered a part of our Association's total program. From these three offerings on the Medicare program, it is hoped that our membership can obtain the information they need to arrive at an individual decision on the matter of Medicare participation or non-participation. The Association itself has not taken a stand. Please complete and mail the form below if you wish to attend the banquet at which Dr. Dwyer will speak.

ROBERT G. SMITH, M. D.
President

Please reserve_____tickets at $10.00 each for the Ohio State Surgical Association reception and banquet at which Dr. Thomas L. Dwyer, President of the Association of American Physicians and Surgeons, will speak.

_____Enclosed is my check for _____. I understand that there will be no additional charges during the reception hour preceding the banquet.

_____ I will pay upon arrival.

Thank you.

_____
name (please print or use stamp)

_____
address

_____ member _____ non-member

Mail to: Ohio State Surgical Association
526 E. Dunedin Rd.
Columbus, Ohio 43214

Ad Astra

Fred W. Dixon, M. D., distinguished Cleveland physician and surgeon of long standing, and Past President of the Ohio State Medical Association, died on April 11 at the age of 77.

First elected to The Council of OSMA in 1944, Dr. Dixon served as Councilor of the Fifth District for six years before he was named President-Elect in 1950. He served on The Council respectively as President-Elect for the 1950-1951 term, President for 1951-1952, and Immediate Past President for 1952-1953. Before being named to The Council, he was for five years on the OSMA Committee on Scientific Works and prior to that served as secretary and chairman, respectively, of the Section on Eye, Ear, Nose and Throat.



Dr. Dixon

Dr. Dixon received his medical degree from the University of Pennsylvania Medical School in 1917, and, after the internship in Youngstown, went into military service during World War I. After the war he located in Leetonia where he engaged in general practice for four years. He studied at the New York Eye and Ear Infirmary and in Vienna before opening his practice in Cleveland for specialization in otolaryngology.

He was certified by the American Board of Otolaryngology, was a member of the American Academy of Ophthalmology and Otolaryngology, a member and past president of the American Laryngological Association, member of the American Laryngology, Rhinology and Otology Society; member of the American Broncho-Esophagological Association and editor of its publication; Fellow of the American College of Surgeons, and former member of its board of governors.

He served on the faculty of Western Reserve University School of Medicine and wrote extensively for medical publications in his specialty field.

Survivors include his widow, a sister, a brother, George Dixon, D. D. S., of Struthers.

Joseph Henry Clouse, M. D., Somerset; Ohio State University College of Medicine, 1921; aged 68; died March 16; member of the Ohio State Medical Association and the American Medical Association. A native of the Somerset area, Dr. Clouse returned there to practice after completing his medical training. He was stricken while attending a patient and died before reaching the hospital. A veteran of World War I, he was a member of the American Legion. Other affiliations include membership in the Catholic Church. Survivors include a daughter, a son, two sisters, and two brothers.

Charles Kenneth Ervin, M. D., Cincinnati; University of Cincinnati College of Medicine, 1910; aged 86; died March 26; former member of the Ohio State Medical Association. A practicing physician of long standing in Cincinnati, Dr. Ervin retired in 1947. He served in the Army Medical Corps during World War I and attained the rank of major. A member of the Presbyterian Church, he is survived by his widow, a daughter and a sister.

Thomas D. Hunnicutt, M. D., Cincinnati; University of Cincinnati College of Medicine, 1943; aged 47; died March 23; member of the Ohio State Medical Association and the American Academy of General Practice. Dr. Hunnicutt entered practice after serving in the Armed Forces during World War II. He was a general practitioner for about 19 years in the College Hill area. Surviving are his widow, a son, a daughter, his parents and a sister.

Lawrence Neff Irvin, M. D., Lima; Ohio State University College of Medicine, 1930; aged 60; died March 17; member of the Ohio State Medical Association, the American Medical Association, the American College of Physicians, and the American Society of Internal Medicine; diplomate of the American Board of Internal Medicine. A native of Lima, Dr. Irvin returned there to practice internal medicine in 1949. He previously was engaged in general practice at Ohio City. He was a past president and former secretary of both the Van Wert County Medical Society and Academy of Medicine of Lima and Allen County. Other affiliations included memberships in several Masonic bodies. Surviving are his widow, a son, three brothers and a sister.

Bela Klein, M. D., Cincinnati; Friedrich Wilhelms University Faculty of Medicine, 1930; aged 63; died April 3; member of the Ohio State Medical Association, the American Medical Association, and the American Psychosomatic Society. A native of Hungary, Dr. Klein came to this country after receiving his medical education in Europe, and practiced for about 30 years in Cincinnati. Survivors include his widow and a son; also two sisters who are residents of Israel.

Carl Allinger Koch, M. D., Cincinnati; University of Cincinnati College of Medicine, 1930; aged

64; died March 14; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A Cincinnati physician since 1929, Dr. Koch was a veteran of World War II, during which he served in the Air Force Medical Corps. He was a past president of the Child Health Association and the Cincinnati Pediatrics Society. Surviving are his widow, a son and a daughter; also a sister.

Orville J. Lighthizer, M. D., Ashtabula; New York University School of Medicine, 1936; aged 61; died March 5; member of the Ohio State Medical Association and the American Medical Association. A physician and surgeon in Ashtabula since 1941, Dr. Lighthizer accepted the post as city health commissioner six years ago and has held it since. He was a member of the Episcopal Church. Survivors include two sons, two brothers and two sisters.

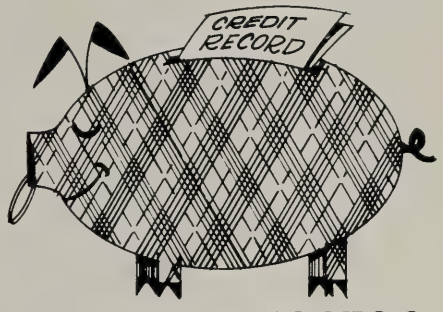
Warren L. Strohmenger, M. D., Cincinnati; University of Louisville School of Medicine, 1931; aged 59; died March 21; member of the Ohio State Medical Association and the American Academy of General Practice. A practicing physician for many years in Cincinnati, Dr. Strohmenger was deputy Hamilton County coroner for 19 years. He was an officer in the Naval Reserve and during World War II served in active duty in the South Pacific. A member of the Masonic Lodge, he is survived by his widow and a daughter.

Sigmund Henry Smedal, M. D., Mansfield; Harvard University Medical School, 1936; aged 54; died March 23; member of the Ohio State Medical Association, the American Medical Association, American Society of Anesthesiologists, and the International Anesthesia Research Society. A physician in Mansfield, specializing in anesthesiology since 1949, Dr. Smedal served in the Army Medical Corps during World War II, and served 30 months in the Mediterranean Theater. In addition to his professional affiliations, he was a member of the Chamber of Commerce. Survivors include his widow and a sister.

Rose Symmes, M. D., Toledo; Cincinnati Medical College, 1903; aged 95; died March 22. Dr. Symmes practiced in Dayton until she married in 1908, when she and her husband moved to Cygnet, Ohio. When her husband died in 1951, she moved to Toledo.

The drug concern which first devised a method of making cortisone from cattle bile used over 32 processing steps and 20 patented inventions and lost money selling the arthritis drug at $200 per gram in 1949. By the end of 1951, further processing improvements made it possible to reduce the price of cortisone to 45 cents per gram.

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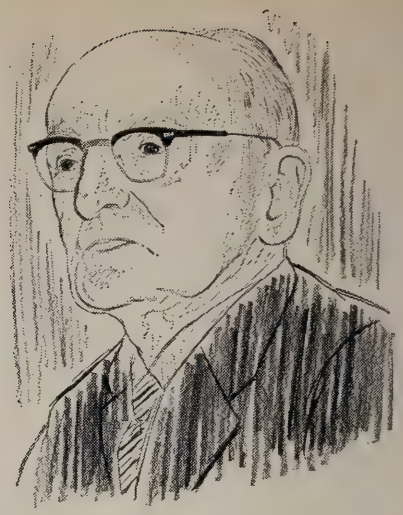
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Honors to Dr. Platter . . .

118th OSMA Annual Meeting Will Be Dedicated To Patriarch of Medical Profession in Ohio



THE 118th Annual Meeting of the Ohio State Medical Association will be dedicated to Herbert Morris Platter, M. D., who retired on January 1, 1966, after 48 years of service to the medical profession and the public as Secretary of the State Medical Board of Ohio.

Dr. Platter will be appropriately honored during the First Session of the Association's House of Delegates on Tuesday, May 24, at the Sheraton-Cleveland Hotel. The session will open at 6:00 P. M. (D. S. T.) Honors will be bestowed by representatives of the Association, the State Medical Board and the State of Ohio. Participating in the ceremonies will be Henry A. Crawford, M. D., OSMA President, and John W. Brown, Ohio's Lieutenant Governor.

Below is an excerpt from an editorial which was published in the June, 1931 issue of *The Ohio State Medical Journal* upon the occasion of Dr. Platter's election to the office of President-Elect of the Association:

"By selecting Dr. H. M. Platter of Columbus as President-Elect, the House of Delegates again followed the long-established precedent that none but the best deserve the honor or are capable of meeting the requirements of the presidency.

"For many years, Dr. Platter has been a wheelhorse in organized medicine in Ohio, serving as counsel and adviser for many who have found the numerous problems and questions of organization activities confusing and perplexing. While serving as treasurer of the State Association for the past 14 years, Dr. Platter has never confined his active interest in organized medicine to that particular office, but, at all times, has been willing to give his time, splendid judgment and experience to the Council and the various Association Committees. His advice on matters of public policy has been solicited time and time again and found of immeasurable value to those faced with the responsibility of making important decisions on matters involving principles and procedure. His knowledge on questions relative to medical education and licensure, obtained in part from many years of active participation in licensure activities as secretary of the State Medical Board and as an official and former President of the National Federation of State Licensing Boards, has stamped him a nation-wide authority in this particular field.

"Dr. Platter's keen understanding of social and economic problems affecting medicine has made him a most valuable conferee for committees studying these questions. His experience in public health work has given him a broad insight into the innumerable problems in that field of medicine. His modest, courteous, kindly, sincere, gentlemanly and gracious manner, coupled with his loyalty to the ideals of medicine and his unselfish desire to serve in every way possible to advance the cause of his profession and to work for the best interests of the public generally, have marked him a peer among the outstanding citizens of his community, home city and state, and established his ability to serve as a leader among his professional colleagues."

This excerpt summarizes Dr. Platter's life as a citizen and a physician and makes clear the reasons for honoring him by dedicating the Annual Meeting to him. A resolution formalizing this action will be presented at the First Session of the House of Delegates. That resolution is printed on page 481 of this issue.

Set forth below is the complete schedule of events for Tuesday night, May 24:

TUESDAY, MAY 24

5:00 P. M. (D. S. T.)

House of Delegates Registration

(Gold Room Assembly, Mezzanine Floor)

6:00 P. .M (D. S. T.)

House of Delegates Complimentary Dinner for Delegates, Alternates, and OSMA Council

(Whitehall Room, Mezzanine Floor)

7:30 P. M. (D. S. T.)

House of Delegates First Business Session

(Gold Room, Mezzanine Floor)

Invocation — The Reverend Frederick T. Schumacher, The First Church in Oberlin, Oberlin.

Welcome by David Fishman, M. D., Cleveland, Academy of Medicine of Cleveland and Cuyahoga County.

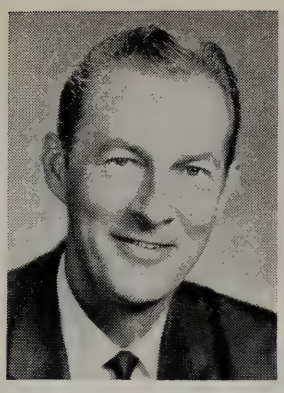
Introduction of President Henry A. Crawford, M. D., Cleveland.

Roll Call of Delegates.

Consideration of the Minutes of the last Annual Meeting (July, 1965 issue of *The Journal).*



Dr. Crawford



Lt. Gov. Brown

Introduction of honored guests.

Presentation of AMA-ERF checks to representatives of the University of Cincinnati College of Medicine; Western Reserve University School of Medicine; and Ohio State University College of Medicine — Robert S. Martin, M. D., Chairman, Ohio Committee on AMA-ERF.

Presentation of plaques honoring physicians serving with Project Viet Nam — Dr. Crawford.

Ceremonies honoring Herbert Morris Platter, M. D., Secretary of the Ohio State Medical Board for 48 years, to whom the entire 1966 Annual Meeting is dedicated. Participating in the ceremonies will be: Dr. Henry A. Crawford, President of the Ohio State Medical Association, Lt. Governor John W. Brown and others.

Report by the President of the Woman's Auxiliary — Mrs. Herbert F. VanEpps, Dover.

Appointment of Reference Committees by the President:

Credentials
President's Address
Resolutions
Tellers and Judges of Election

Nomination and election of Committee on Nominations: (Nominations from the floor. One representative (delegate) from each Councilor District. The Committee shall report to the Final Session, Friday, May 27, 9:00 A. M., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Friday morning session before any action can be taken. All resolutions must be typewritten and submitted in triplicate.)

Announcement of meeting places of Reference Committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

Ohioans Have Special Interest in Coming AMA Annual Convention

Ohioans will have a particular interest in the coming 115th American Medical Association Annual Convention in Chicago, June 26-30. During the Convention, Dr. Charles L. Hudson, of Cleveland, who is now serving as AMA President-Elect will be installed as President for the coming year. Watch for the June issue and additional information on the inauguration and other highlights of the convention.

This year the AMA Annual Convention presents an even wider and greater range of medical subjects than before, even though the scope of subjects covered has been increasing from year to year.

This year's convention will be held in the magnificient McCormick Place, one of the largest and most modern facilities available anywhere. Among features will be six general scientific meetings; 23 medical specialty programs; 800 scientific and industrial exhibits; lectures, panel discussions, motion pictures and color television.

The May 9 issue of *The Journal of the AMA* will contain the complete program.

The American College of Chest Physicians will again join the AMA Section on Diseases of the Chest in an all day program.

The American College of Cardiology and the American Heart Association will join the AMA Section on Internal Medicine in a half-day session.

The American Society of Clinical Pathologists will join the AMA Section on Pathology and Physiology in a half-day session on Computers in Medicine.

The foregoing are only a few examples of the many specialty organizations that are cooperating in the AMA program. Medical Motion Pictures and Color Television programs will be presented daily, and some of the Sections will participate in these programs.

House of Delegates functions will be in the Palmer House. Watch for May 9 *JAMA* and details.

A special feature of the AMA Convention will be a guided tour of the AMA headquarters facilities at 535 N. Dearborn Street, and the new Institute for Biomedical Research. All physicians, their wives and guests are invited to tour the building.

The Woman's Auxiliary to the AMA will hold its 43rd annual convention June 26-30. On June 26, a reception will honor the Auxiliary president and the president-elect. On Tuesday, June 28, national past presidents and AMA officers, trustees, and their wives will be guests of honor at a luncheon.

Persons planning to attend the convention are advised to refer to advance registration forms and housing accommodation forms now appearing in AMA publications. Advance registrations save precious time at the convention. Advance housing reservations are a must for any convention as extensive as the AMA Annual Convention.

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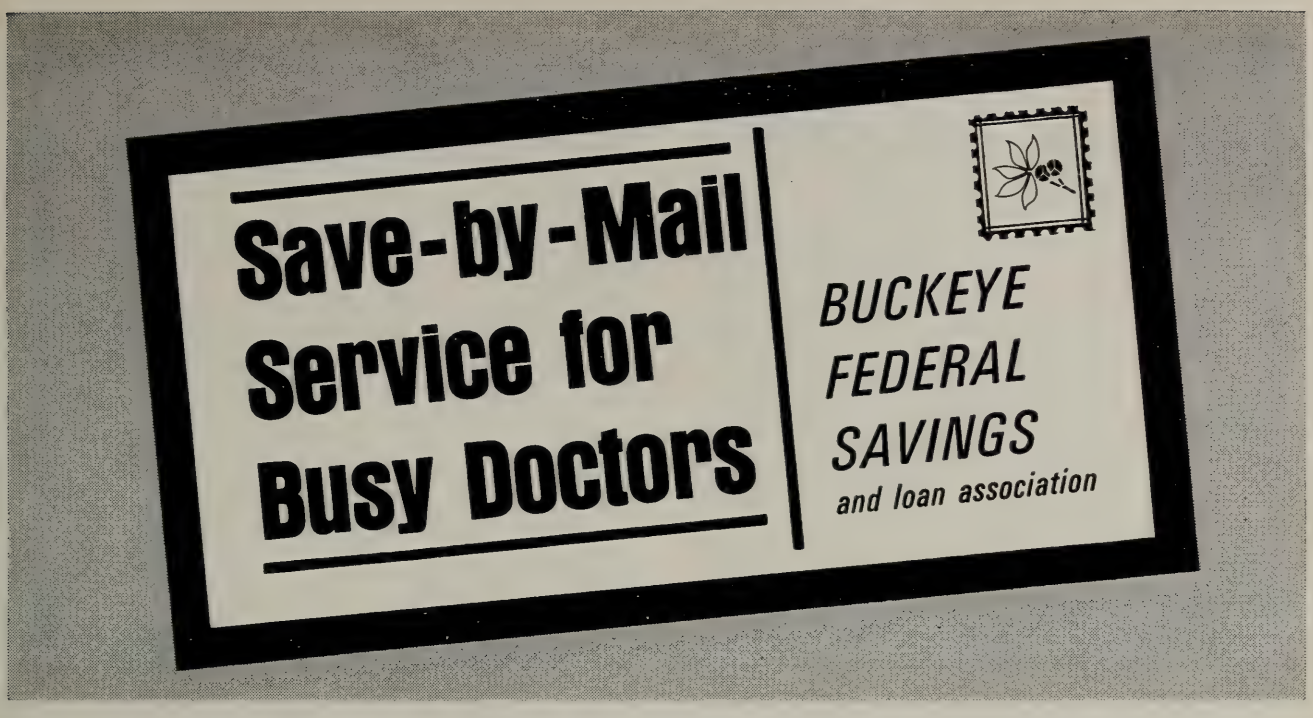
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Woman's Auxiliary Highlights ...

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

THE YEAR is drawing to a close for Mrs. Herbert F. Van Epps as president of the Woman's Auxiliary to the Ohio State Medical Association. It has been a good year, and she has been a good president. For those of us who have had the privilege of working with her, that previous statement did not need to be said, because we are all well aware of it. But to the many doctors' wives throughout the state to whom the name of the State president is better known than the lady herself, it seems fitting at this time to point out that we have had a conscientious, interested, competent, keenly aware leader who has never spared herself, and who has always had a sympathetic ear for anyone — and everyone!

It has not been customary to give accolades to retiring presidents in this column, which has been a serious oversight, I think (and one of which I myself have been guilty). Any woman who assumes the presidency of the State Auxiliary gives so much of herself to the job that it is difficult to comprehend and appreciate it fully. We — the members of the Auxiliary — owe her a deep debt of gratitude. We owe it to her too to be present at her Convention — to show her, by our very presence, that we have been and are behind her and that we are truly grateful for all she has done. To Mary Louise Van Epps — our own printed orchid for a job well done!

Come to Convention, won't you? It's in Cleveland this year, at the Sheraton-Cleveland Hotel — May 24 through 27. It will be a time of accomplishment and a time of fun. You can't afford to miss it.

The OMPAC Luncheon

This is a Convention "must" — on Wednesday, May 25, in the Gold Room, Mezzanine Floor, Sheraton-Cleveland Hotel, the luncheon at 12:00 NOON sponsored by the Ohio Medical Political Action Committee. Cost of the luncheon — $5 per person. Dr. Frank Mayfield, chairman of OMPAC, will be the presiding officer and will present vital legislative and political problems confronting the medical profession as well as present a progress report on OMPAC. Dr. Hoyt Gardner, member of the Board of Directors of AMPAC, will speak on "Success Can Be Ours." Dr. Gardner is a diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons who practices in Louisville, Kentucky. His outstanding activity in the KEMPAC and AMPAC organizations qualifies him well to present the story on Political Action. Following Dr. Gardner's talk, there will be a period for questions and answers.

All you local legislative chairmen — take note! Do everything you can to help sell tickets for this luncheon. This occasion is far more than a luncheon — it is a school of instruction for every doctor's wife — an opportunity to learn so that you in turn can pass on information that is **vital**. Whether you like it or not, politics is **your** business!! Every citizen has a duty to promote good government. People like us have a special responsibility to be well informed and prepared to answer others on affairs of government and politics.

Don't by-pass this important luncheon. The most valuable thing you can shop for Wednesday, May 25, at noon, is KNOW-HOW. And that KNOW-HOW is yours for the taking in the Gold Room of the Cleveland-Sheraton Hotel.

Around the State

From the **Clermont County** auxiliary has come an interesting "bird's-eye" view of its activities this year that included an all-out campaign on a hospital bond issue, a Community Service Program from Home Health Aids and Family Service of the Cincinnati area, and a Safety in the Home program.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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425 E. 15th St., Dover 44622

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2. Mrs. M. W. Sloan, II
415 Towerview Rd., Dayton 45429
3. Mrs. Edward L. Doerman
3605 Laskey Rd., Toledo 43623

Past-President and Nominating Chairman:
Mrs. John D. Dickie
2146 Shenandoah Rd., Toledo 43607

President-Elect: *Mrs. James Wychgel*
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Recording Secretary: Mrs. J. W. Loney
15450 Hemlock Point Rd., Chagrin Falls

Corresponding Secretary: Mrs. C. Raymond Crawley
1507 Seven Mile Dr.,
New Philadelphia 44663

Treasurer: Mrs. R. L. Wiessinger
2280 W. Wayne St., Lima 45805

To raise funds for AMA-ERF, the Clermont women have come up with a novel idea — to have a "surprise packet" at each meeting to be chanced off. Each person attending buys a slip of paper for a dollar. On each slip is written something in the same category as the packet. At one meeting, it was 20 pounds of apples and the slips were written in French. At another, a book "Design with Flowers" was the surprise. At still another time, the surprise packet was an outstanding centerpiece that featured a huge square white and gold candle. Recently, in keeping with the season, a "Breath of Spring" gift package featured the AMA-ERF gimmick. No end, seems like, to the ingenuity of doctors' wives!

The **Hamilton County** group has come up with some more of its outstanding newspaper publicity — this time the *Cincinnati Post and Times-Star* has devoted almost two-thirds of a page to a terrific story on the Apple Tree (you recall that is the unusual children's day-care center run by the auxiliary to enable mothers who are nurses and other important hospital personnel to continue to work in the hospitals that need their services so badly). The group held a highly successful "Flower Basket of Fashion" at the Lookout House on March 15, following a luncheon. Daytime clothes, sportswear, casuals and evening gowns by famous designers were modeled by 23 physicians' wives in cooperation with Gidding-Jenny of Cincinnati.

With flowers still holding the center of the stage, the Hamilton women came up with something new at their April meeting — creating floral arrangements in containers from the medical laboratory! It happened on April 19 and the place was, fittingly enough, the Cincinnati Art Museum. Mrs. Francis Gleason, accredited flower judge, discussed "Fleurs d'Avant Garde." Mrs. Gleason is a teacher on abstract arrangements at the Garden Center and is the author of "Think a Theme," a book of ideas for flower shows. Importance of flowers in man's pharmaceutical progress prompted Mrs. John Toepfer, local president, to invite members of the Pharmaceutical Association Auxiliary to share the program. The wives of foreign physicians serving internships and residencies in Cincinnati hospitals were also Auxiliary guests. Mrs. John Marioni, chairman of international hospitality, was in charge of those arrangements. Garden hobbyists who contributed the "avant garde" floral arrangements included: Mrs. Charles D. Feuss, Mrs. Kenneth Frederick, Mrs. J. Philip Fox, Mrs. N. G. Amato, Mrs. Robert J. Anzinger, Mrs. Joseph M. Casper, Mrs. Edward J. Devins, Mrs. Lowell E. Golter, Mrs. Maurice D. Marsh, Mrs. James S. Mills, Mrs. Robert E. Khuon, Mrs. Lester W. Sanders, Mrs. Carl H. Wendel, Mrs. Walter B. Wildman and Mrs. L. F. Zacharis, Mrs. E. A. Kindel, Jr., was in charge of arrangements for the luncheon.

Goings-On in Lucas

Here is another auxiliary group always doing something that smacks of the unusual. In early March, the **Lucas County** group and the Academy held a joint meeting about the current water pollution problem. "Apathy or Action" was the program's title. Mrs. Paul Findlay and Dr. G. Harrison Orians, of the Toledo University faculty, presented the case for a cleaner Maumee.

The spring session of the Adoptive Parents Classes started in March at the Board of Education building. Mrs. Burton Nelson is chairman of the project.

The annual Bridge Luncheon of the Lucas women was held on April 19 at the Academy. This is an annual AMA-ERF event with a door prize, individual table high score gifts and chances on additional prizes. Mrs. John Van der Veer was chairman, with Mrs. Harvey Muehlenbeck serving as cochairman. The annual recognition luncheon for CDC volunteers was held on April 25. This year's theme, as announced by Mrs. A. J. Kuehn, was a "Royal Luncheon for Citizen's Day Care Queens." Mrs. Spencer Northup was chairman of the day's activity. Mrs. Daniel Wolff, Health Careers chairman, was in charge of the annual field trip on April 23 to Henry Ford Hospital in Detroit. An invitational dessert



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meeting in March featured a talk on contemporary poets by the interim pastor at First Unitarian Church, Dr. Herbert Hitchen. Mrs. Brian Bradford and Mrs. Jack Burnheimer served as cochairmen, assisted by Mrs. Max Schnitker and Mrs. J. M. Hobbs.

At a recent "Aircade for Citizenship Action," the auxiliary was represented by Mrs. John Dickie and Mrs. Daniel Sullivan. The Aircade is an annual event sponsored by the U. S. Chamber of Commerce, during which a group of panelists is flown in chartered planes to various cities across the nation. This year, Toledo was host to the third of a series of 15 such meetings. The panel urges political action and is well set up to handle questions from the floor. They covered such current topics as urban renewal, medicare, regional development, farm legislation, the Appalachia program, minimum wage increase, and so on. The Lucas County auxiliary, like its sister auxiliary in Hamilton County, is particularly fortunate in its excellent newspaper coverage. Mrs. Charles M. Klein, whose job it is to keep this column informed on her group's doings, never fails to have a batch of clippings to send each month. Could I possibly be — hinting — that perhaps other groups have plenty of clippings too, only they're not coming my way?

REMEMBER — all roads lead to Cleveland and a wonderful convention.

Ohio State University Offers Courses for Physicians

Ohio State University College of Medicine, Columbus, offers a number of postgraduate courses of interest to physicians. Information on these courses may be obtained by contacting the Center for Continuing Medical Education at the Medical Center. Among courses offered in the near future are the following:

Third Annual Professional Symposium on Kidney Disease, May 11, jointly sponsored by the Central Ohio Chapter of the National Kidney Foundation.

Fourth Annual Occupational Medicine Postgraduate Course, June 20-24.

Library Photoduplication Service Offered to Research Groups

The library of the National Society for Crippled Children and Adults has initiated a library photoduplication service to persons engaged in rehabilitation research. As a research project, the service is supported in part by a one-year grant of $10,902 from the U. S. Vocational Rehabilitation Administration.

The service is available without charge to personnel in any educational or research institution and any health or welfare agency, public or private, who may be engaged in rehabilitation research. When a needed journal reference is not available from local resources, the person may request a photocopy from the library of the National Society, at 2023 W. Ogden Ave., Chicago.

A Future in Family Medicine Is Topic for OSU Lecture

Dr. Robert E. Carter, assistant dean of the University of Iowa College of Medicine, spoke on the topic, "A Future in Family Medicine" at a recent Ohio State University College of Medicine lecture program.

Dr. Carter, who is also a professor of pediatrics, served his internship at Cleveland City Hospital and received his residency training at the University of Chicago Clinic.

He was a Markle Scholar in the Medical Sciences from 1957-62, is a fellow of the American Academy of Pediatrics, and a member of the Society for Pediatric Research.

Hobbyists are warned by the USPHS to use silver solder containing cadmium metal only with caution. Vapors resulting when this product is overheated can be dangerous. Cadmium is used only in certain types of silver solder. The commonly used tin-based solders do not present this hazard, the report states.



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Committee on Radiation—Charles M. Barrett, Cincinnati, Chairman; Eldred B. Heisel, Columbus; George F. Jones, Lancaster; Carey B. Paul, Jr., Columbus; Thomas C. Pomeroy, Columbus; Denis A. Radefeld, Lorain; Eugene L. Saenger, Cincinnati; Robert E. Schulz, Wooster; John P. Storaasli, Cleveland; Robert P. Ulrich, Troy; Robert L. Wall, Columbus; John Robert Yoder, Toledo; James G. Kereiakes, Ph. D. (Advisory Member, Special Consultant), Cincinnati.

State Association Officers and Committeemen (Continued)

Committee on Rural Health—Robert E. Reiheld, Orrville, Chairman; Chester J. Brian, Eaton; J. Martin Byers, Greenfield; Walter A. Campbell, Coshocton; E. Joel Davis, East Canton; Victor R. Frederick, Urbana; Benjamin W. Gilliotte, Zanesville; Jerry L. Hammon, West Milton; Jasper M. Hedges, Circleville; Luther W. High, Millersburg; E. D. Mattmiller, Athens; John R. Polsley, North Lewisburg; Leonard S. Pritchard, Columbiana; Harold C. Smith, Van Wert; Kenneth W. Taylor, Pickerington; Edmond K. Yantes, Wilmington.

Committee on Scientific and Educational Exhibit—Charles V. Meckstroth, Columbus, Chairman; Harvey C. Knowles, Jr., Cincinnati; W. Arnold McAlpine, Toledo; Arthur E. Rappoport, Youngstown; Arnold M. Weissler, Columbus; Walter J. Zeiter, Cleveland; Robert E. Zipf, Dayton.

Committee on School Health—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Paul D. Hahn, New Philadelphia; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Lawrence L. Maggiano, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Albert E. Thielen, Cincinnati; Homer B. Thomas, Gallipolis.

Committee on Traffic Safety—N. J. Giannestras, Cincinnati, Chairman; Howard W. Brettell, Steubenville; Drew L. Davies, Columbus; Clark M. Dougherty, New Philadelphia; Wesley L. Furste, Columbus; Thomas W. Morgan, Gallipolis; Lester G. Parker, Sandusky; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus; John F. Tillotson, Lima; Robert C. Waltz, Cleveland; Paul L. Weygandt, Akron; Robert E. Zipf, Dayton.

Committee on Workmen's Compensation—H. P. Worstell, Columbus, Chairman; A. L. Berndt, Portsmouth; Thomas H. Brown, Jr., Toledo; Charles A. Browning, Jr., Bellefontaine; Oscar W. Clarke, Gallipolis; Frederick A. Flory, Columbus; Lawrence T. Hadbavny, Cleveland; Clyde O. Hurst, Portsmouth; Edmund F. Ley, Tiffin; Joseph Lindner, Sr., Cincinnati; John D. Osmond, Jr., Cleveland; James G. Roberts, Akron; George L. Sackett, Sr., Painesville; Joseph H. Shepard, Columbus; William V. Trowbridge, Cleveland; Rex H. Wilson, Akron; Frederick A. Wolf, Cincinnati; James N. Wychgel, Cleveland.

OSMA Members of the Joint Advisory Committee on Athletic Injuries—Robert J. Murphy, Columbus; John R. Jones, Toledo; Sol Maggied, West Jefferson; Charles H. McMullen, Loudonville; Carey B. Paul, Jr., Columbus; Thomas E. Shaffer, Columbus; Don A. Kelly, Cleveland; Marvin R. McClellan, Cincinnati; Walter A. Hoyt, Jr., Akron.

OSMA Members of the Joint Committee on School Bus Driver Examinations—Carey B. Paul, Jr., Columbus; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus.

DELEGATES AND ALTERNATES

Delegates and Alternates to the American Medical Association—George W. Petznick, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Theodore L. Light, Dayton; Kenneth D. Arn, Dayton, alternate; Edmond K. Yantes, Wilmington; Harry K. Hines, Cincinnati, alternate; John H. Budd, Cleveland; P. John Robechek, Cleveland, alternate; Richard L. Meiling, Columbus; Robert E. Tschantz, Canton, alternate; Frederick F. Osgood, Toledo; Robert N. Smith, Toledo, alternate; Charles A. Sebastian, Cincinnati; J. Robert Hudson, Cincinnati, alternate; Edwin H. Artman, Chillicothe; Philip B. Hardymon, Columbus, alternate.

County Societies' Officers and Meeting Dates

First District

Councilor: Robert E. Howard, Cincinnati 45202
2600 Union Central Bldg.

ADAMS—Gary J. Greenlee, President, Manchester 45144; Stanley H. Title, Secretary, Manchester 45144.

BROWN—Charles H. Maly, President, Sardinia 45171; Charles W. Hannah, Secretary, Sardinia 45171. 1st Monday monthly.

BUTLER—Robert Johnson, President, 500 S. Breiel Boulevard, Middletown 45042; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 4th Wednesday monthly.

CLERMONT—Cecil F. Barber, President, State Route 133, Felicity 45120; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond 45157. 3rd Wednesday monthly, except July and August.

CLINTON—Richard R. Buchanan, President, 115 West Main, Wilmington 45177; Mary Ranz Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Robert M. Woolford, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Monthly meeting dates, 1st Tuesday; Academy, 3rd Tuesday, except June, July and August.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Walter Felson, Secretary, 357 South St., Greenfield 45123. 3rd Tuesday bimonthly.

WARREN—O. Williard Hoffman, President, 20 East Fourth Street, Franklin 45005; Ray E. Simendinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: Theodore L. Light, Dayton 45406
2670 Salem Ave.

CHAMPAIGN—Myron J. Towle, President, 848 Scioto Street, Urbana 43078; Fred R. Denkewalter, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—Henry M. Tardif, President, 2608 E. High Street, Springfield 45505; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield 44501. 3rd Monday monthly, except June, July and August.

DARKE—William A. Browne, President, 722 Sweitzer St., Greenville 45331; Delbert D. Blickenstaff, Secretary, 552 S. West St., Versailles 45380. 3rd Tuesday monthly.

GREENE—Clement G. Austria, President, 1142 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly except July and August.

MIAMI—David Brown, President, 1060 North Market Street, Troy 45373; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua 45356. 1st Tuesday monthly.

MONTGOMERY—Charles E. O'Brien, President, 600 Fidelity Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly October through May — 1st Wednesday June.

PREBLE—John D. Darrow, President, 228 N. Barron St., Eaton 45320; Willard C. Clark, Jr., Secretary, 228 N. Barron, Eaton 45320. Irregular meetings.

SHELBY—George J. Schroer, President, 322 Second Ave., Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney 45365.

Third District

Council: Frederick T. Merchant, Marion 43305
1051 Harding Memorial Pky.

ALLEN—Carl H. Zinsmeister, President, 729 W. Market Street, Lima 45801; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly.

AUGLAIZE—Robert Sobocinski, President, 75 Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring Street, St. Marys 45885. 1st Thursday monthly except July.

CRAWFORD—Don E. Ingham, President, 201 N. Market Street, Galion 44833; Johnson H. Chow, Secretary, 1040 Devonwood Drive, Galion 44833. Called meetings.

HANCOCK—Raymond J. Tille, President, 801 S. Main St., Findlay 45840; Herbert L. Queen, Secretary, 828 Woodworth Dr., Findlay 45840.

HARDIN—William D. Dewar, President, 405 North Main Street, Kenton 43326; John J. Roget, Secretary, Belle Center 43310. 2nd Tuesday monthly.

LOGAN—Thomas Seitz, President, 223 E. Columbus Street, Bellefontaine 43311; Glen Miller, Secretary, R. D. 2, West Liberty 43357. 1st Friday monthly.

MARION—Ransome Williams, President, 1035 Harding Memorial Parkway, Marion 43302; Alice Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—R. Duane Bradrick, President, Rockford 45882; R. L. Dobbins, Secretary, 5402 State Route 29 East, Celina. 3rd Thursday, monthly.

SENECA—Olgierd C. Garlo, President, 53 Clay Street, Tiffin 44883; Leonard M. Gaydos, Secretary, 233 South Monroe Street, Tiffin 44883. 3rd Tuesday monthly.

VAN WERT—Norman L. Marxen, President, Medical Arts Bldg., Fox Road, Van Wert 45891; W. L. Iler, Secretary, Medical Arts Bldg., Fox Road, Van Wert 45891. 4th Friday monthly.

WYANDOT—Herschel A. Rhodes, President, 777 N. Sandusky Ave., Upper Sandusky 43351; J. J. Browne, Secretary, 777 N. Sandusky Ave., Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—L. F. Berry, Jr., President, 1400 East Second Street, Defiance 43512; W. S. Busteed, Secretary, Box 218, Defiance 43512.

FULTON—B. H. Reed, Jr., President, Delta 43515; R. L. Davis, Secretary, Wauseon 43567. 2nd Tuesday quarterly March, June, September, December.

HENRY—J. J. Harrison, President, 113 East Clinton Street, Napoleon 43545; Gamble S. Hall, Secretary, 834 Strong Street, Napoleon 43545. 1st Tuesday monthly.

LUCAS—E. L. Doermann, President, 2001 Collingwood Blvd., Toledo 43620; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday monthly except July and August.

OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.

PAULDING—Roy R. Miller, President, 220 W. Perry, Paulding 45879; D. Paul Ward, Secretary, Box 416, Oakwood 45873. Meetings called.

PUTNAM—Arthur P. Daniel, President, 144 N. Walnut, Ottawa 45875; Oliver N. Lugibihl, Secretary, Pandora 45877. 1st Tuesday monthly.

SANDUSKY—J. L. Zimmerman, President, Memorial Hospital of Sandusky County, Fremont 43420; Mrs. Patsy J. Askins. Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.
WILLIAMS—John E. Moats, President, Central Drive, Bryan 43506; Neil T. Levenson, Secretary, 907 Noble Drive, Bryan 43506. 2nd Tuesday monthly.
WOOD—Roger A. Peatee, President, 140 S. Prospect Street, Bowling Green 43402; William B. Elderbrock, Secretary, Health Service, Bowling Green State University, Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44106
10525 Carnegie Ave.

ASHTABULA—J. R. Nolan, President, 2736 Lake Avenue, Ashtabula 44004; Richard Millberg, Secretary, 430 West 25th Street, Ashtabula 44004. 2nd Tuesday monthly.
CUYAHOGA—William F. Boukalik, President, 20030 Scottsdale Boulevard, Cleveland 44122; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.
GEAUGA—Bruce F. Andreas, President, 400 Downing Drive, Chardon 44024; Arturo J. Dimaculangan, Secretary, 8400 Mayfield Road, P. O. Box 277, Chesterland 44026. 2nd Friday monthly.
LAKE—Robert W. Colopy, President, 89 E. High Street, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening monthly, January, May, March, September and November unless otherwise ordered by Council.

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

COLUMBIANA—Edith S. Gilmore, President, 432 W. 5th St., E. Liverpool 43920; Fraser Jackson, Secretary, 205 W. 6th St. 3rd Tuesday monthly.
MAHONING —F. A. Resch, President, Doctors Park, Canfield 44406; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly except July and August.
PORTAGE—David Palmstrom, President, 124 North Prospect Street, Ravenna 44266; William R. Brinker, Secretary, 141 East Main Street, Kent 44240. 3rd Tuesday monthly.
STARK—A. R. Furnas, Jr., President, 420 Lake Avenue, N. E., Massillon 44646; Mr. John H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.
SUMMIT—James G. Roberts, President, 655 West Market Street, Akron 44303; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, 159 South Main Street, Akron 44308. 1st Tuesday monthly.
TRUMBULL—John F. McGreevey, President, 297 Hawthorne Lane N. E., Warren 44484; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly September through May.

Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry 43935
30 S. 4th St.

BELMONT—James Sutherland, President, 9 North 4th Street, Martins Ferry 43935; Bertha M. Joseph, Secretary, 100 South 4th Street, Martins Ferry 43935. 3rd Thursday of February, March, April, June, September, October, November and December.
CARROLL—Glen C. Dowell, President, 207 West Main, Carrollton 44615; Thomas J. Atchison, Secretary, 292 East Main, Carrollton 44615. 1st Thursday monthly.
COSHOCTON—Don Warren, President, 600 East Main Street, West Lafayette 43845; Harold Lear, Secretary, 133 South Fourth Street, Coshocton 43812. 2nd Tuesday monthly.
HARRISON—Charles D. Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988, Quarterly.
JEFFERSON—Jacob R. Cohen, President, 341 Market Street, Steubenville 43952; Irving Dreyer, Secretary, Ohio Valley Hospital, Steubenville 43952. 4th Tuesday monthly except December, January, February.
MONROE—Byron Gillespie, Secretary, Woodsfield 43793.
TUSCARAWAS—Robert J. Kuba, President, 319 Grant St., Dennison 44621; Thomas E. Ogden, Secretary, 138 E. Main St., Gnadenhutten. 2nd Thursday monthly.

Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705
2236 Maple Ave.

ATHENS—D. R. Johnson, President, 52 West Washington Street, Nelsonville 45764; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday monthly except July and August.
FAIRFIELD—George W. LeSar, President, 216 Harmon Avenue, Lancaster 43130; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore 43105. 2nd Tuesday monthly.
GUERNSEY—A. C. Smith, President, 1115 Clark Street, Cambridge 43725; Dayle O. Snyder, Secretary, 840 Wheeling Avenue, Cambridge 43725. 1st Tuesday monthly.
LICKING—Carl L. Petersilge, President, 104 Hudson Avenue, Newark 43055; Robert P. Raker, Secretary, 317 N. Granger Street, Granville 43023. 4th Tuesday monthly.
MORGAN—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, Box 199, Malta 43758.
MUSKINGUM—Paul A. Jones, President, 838 Market Street, Zanesville 43701; Myron Powelson, Secretary, 2825 Maple Avenue, Zanesville 43705. 2nd Tuesday monthly.
NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, 415 Main Street, Caldwell 43724. 1st Tuesday monthly.
PERRY—Charles B. McDougal, President, 319 High St., New Lexington 43764; Michael P. Clouse, Secretary, West Main St., Somerset 43783.
WASHINGTON—Mary L. Whitacre, President, Rt. 6, Marietta 45750; G. E. Huston, Secretary, 328 Fourth St., Marietta 45750. 2nd Wednesday monthly.

Ninth District

Councilor: George N. Spears, Ironton 45638
2213 S. 9th St.

GALLIA—Quentin Korfhage, President, Gallipolis Clinic, Gallipolis 45631; John Groth, Secretary, Holzer Clinic, Gallipolis 45631. Monthly meetings at called times.
HOCKING—Jan S. Matthews, President, 9 East Second Street, Logan 43138; H. M. Boocks, Secretary, Route 3, Logan 43138. 2nd Tuesday monthly.
JACKSON—John M. Cook, President, Box 316, Oak Hill 45656; Earl J. Levine, Secretary, 120 N. Ohio Ave., Wellston 45692.
LAWRENCE—Frank W. Crowe, President, 2110 South 9th Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly at called times.
MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy 45769; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy 45769.
PIKE—Robert T. Leever, President, 100 East Third St., Waverly 45690; Albert M. Shrader, Secretary, East Water St., Waverly 45690. 1st Tuesday monthly.
SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Erich Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. 2nd Monday in February, April and October; December meeting and summer meeting decided by the Council and members notified one month in advance.
VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: Richard L. Fulton, Columbus 43212
1211 Dublin Rd.

DELAWARE—Don K. Michel, President, 98 W. Villiam, Delaware 43015; Tennyson Williams, Secretary, Box 265, Delaware 43015. 3rd Tuesday monthly.
FAYETTE—R. D. Woodmansee, President, 403 East Market Street, Washington C. H. 43160; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday monthly
FRANKLIN—Joseph A. Bonta, President, 3100 Olentangy River Road, Columbus 43202; Mr. W. "Bill" Webb, Jr., Executive Secretary, 79 East State Street, Room 601, Columbus 43215. 3rd Tuesday monthly.
KNOX—Richard L. Smythe, President, 812 Coshocton Road, Mt. Vernon 43050; Robert E. Sooy, Secretary, Box 470, Mt. Vernon 43050. 1st Wednesday evening monthly.
MADISON—Sol Maggied, President, 15 East Pearl Street, West Jefferson 43162; Michael Meftah, Secretary, 11 East 2nd Street, London 43140. 1st Wednesday monthly.
MORROW—Francis W. Kubb, President, 140 North Main, Mt. Gilead 43338; William S. Deffinger, Secretary, Box 8, Marengo 43334. 1st Tuesday monthly.
PICKAWAY—V. D. Kerns, President, 143 E. Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney Street, Circleville 43113. 1st Friday evening monthly, except months of July and August.
ROSS—Joseph McKell, President, 174 W. Main Street, Chillicothe 45601; Lowell O. Smith, Secretary, 217 Delano Avenue, Chillicothe 45602. 1st Thursday evening monthly.
UNION—Malcolm MacIvor, President, 110 N. Court St., Marysville 43040; May B. Zaugg, Secretary, 225 Stockdale Drive, Marysville 43040. 1st Tuesday, February, April, October, December.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Road

ASHLAND—Henry C. Chalfant, President, 309 Arthur Street, Ashland 44805; H. W. Smith, Secretary, 414 Samaritan Avenue, Ashland 44805. 1st Thursday monthly.
ERIE—Clinton F. Lavender, President, 1218 Cleveland Road, Sandusky 44870; R. D. Gillette, Secretary, P. O. Box 127, Huron 44839. Alternate Tuesday and Thursday monthly.
HOLMES—Charles H. Hart, President, 109 South Clay Street, Millersburg 44654; William A. Powell, Secretary, 8 West Adams Street, Millersburg 44654. Monthly meeting date to be determined later.
HURON—W. R. Graham, President, 15 Main Street, Wakeman 44889; E. R. McLoney, Secretary, 257 Benedict Avenue, Norwalk 44857. 2nd Wednesday of February, April, June, August, October, and December.
LORAIN—Joseph A. Cicerrella, President, 209 6th Street, Lorain 44052; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly except June, July and August.
MEDINA—Myrl A. Nafziger, President, Albrecht Building, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina, Ohio 44256. 3rd Thursday monthly.
RICHLAND—C. J. Shamess, President, 74 Wood Street, Mansfield 44903; Harold F. Mills, Secretary, 70 Madison Road, Mansfield 44905. 3rd Thursday monthly except June, July and August.
WAYNE—Howard MacMillan, President, 1740 Cleveland Road, Wooster 44691; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday monthly, January, February, April, September, November and December.

(Continued on page 517)

Activities of County Societies . . .

First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

BUTLER

Dr. Kenneth I. E. Macleod, Cincinnati health commissioner, was principal speaker at the regular meeting of the Butler County Medical Society in Middletown on March 23. His discussion was in regard to advances in the field of immunization.

The dinner meeting was held at the Elks Club.

CLINTON

Dr. Richard Witt, director of pulmonary physiology research at Cincinnati General Hospital, spoke at the meeting of the Clinton County Medical Society Tuesday night (March 22) at Clinton Memorial Hospital, Wilmington. He gave an illustrated lecture on pulmonary function studies in various types of lung diseases. — *Wilmington News-Journal.*

HAMILTON

At the March 15 meeting of the Academy of Medicine of Cincinnati, Dr. David C. Sabiston, Jr., professor and chairman of the Department of Surgery at Duke University, spoke on the topic, "Recent Developments in the Diagnosis and Management of Pulmonary Embolism."

As cosponsor of program to combat venereal disease, the Academy of Medicine of Cincinnati was host for a meeting where a VD film was shown and panel discussion held on March 29.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

GREENE

The Greene County Medical Society has undertaken the sponsorship of three programs of venereal disease education for high school and junior high school students, parents, and teachers.

The program included showing of the films "The Innocent Party" and "Dance, Little Children," as well as discussions by local physicians.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Dr. William H. Saunders, who is associated with the otolaryngology service at Children's Hospital in Columbus, spoke at the March 15 dinner meeting of the Academy of Medicine of Lima and Allen County, where he discussed problems related to deafness.

AUGLAIZE

Dr. Robert Sobocinski was principal speaker at the March meeting of the Auglaize County Medical Society. He reported on the meeting held in Columbus of County Medical Society Officers and Committeemen, stressing latest developments in regard to Medicare and utilization committees in hospitals.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The Section on Pathology of the Academy of Medicine of Toledo met on April 15. Dr. Harry Weisberg, associate professor at the Chicago Medical School, spoke on the topic "Clinical Aspects of Water and Electrolite Metabolism."

The Toledo Medical Library Association held its annual meeting on April 21 at the Academy Build-

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ing. The evening's activities consisted of a social hour, dinner and program.

The Inter-Hospital Postgraduate Lecture Series, presented by the Medical Advancement Trust of Maumee Valley Hospital, is scheduled on May 12 and 13. Dr. Robert D. Johnson, associate professor at the University of Michigan, will speak on recent advances in medicine, especially in regard to diabetes mellitus, diabetic coma, hypertension, primary aldosteronism and hypercalcemia.

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

CUYAHOGA

The April issue of *The Bulletin* of the Academy of Medicine of Cleveland contained photographs of candidates for election to the Board of Directors of the Academy.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

The inclusion of physicians under Social Security was the subject for discussion at the February 15 meeting of the Mahoning County Medical Society. Featured speaker was William J. McCauley, district manager of the Youngstown Social Securirty office. The interest of members in the subject was indicated by an increase in attendance.

At the March 15 meeting, Dr. Nicholas Nyaradi, director of the School of International Studies at Bradley University, and a former minister of finance of Hungary, spoke on world communism. The occasion was the 12th annual joint meeting of the Mahoning County Medical Society and the Mahoning County Bar Association. Because of the general interest in the speaker, wives of the physicians and attorneys were guests. More than 200 persons heard Dr. Nyaradi, a strong anticommunist and supporter of the free enterprise system.

Both programs were arranged by Dr. Jack Schreiber, program chairman and past president. Dr. F. A. Resch, president, presided.

* * *

The Mahoning County Medical Society presented a $50 scholarship and a trophy for the best project related to the field of medicine at the Tri-County (Mahoning, Trumbull, Columbiana) High School Science Fair, held at Austintown Fitch High School recently.

Winner was Karen Wattenbarger, a 17 year-old Junior, whose project demonstrated the effect of an overdose of vitamin A on mice. Dr. John Melnick, chairman of the medical society's youth committee, judged the more than 50 medical exhibits and presented the award to the winner.

This marked the first year that the Mahoning County Medical Society entered the science fair.



Dr. John Melnick presents the Mahoning County Medical Society trophy to Miss Karen Wattenbarger.

Society members were pleased with the results and plan to make a yearly award to encourage interest in medicine among high school students.

STARK

The importance of a hobby was portrayed to members of the Stark County Medical Society on March 10 when Marc Moon discussed the rewarding satisfaction of water color painting while demonstrating his talent. A resident of Cuyahoga Falls, Mr. Moon is a member of the American Water Color Association and has exhibited his work both regionally and nationally.

SUMMIT

The Summit County Medical Society held its monthly membership meeting on April 5 in the Children's Hospital auditorium in Akron. Among subjects on the program for consideration were resolutions to be presented at the OSMA Annual Meeting Medicare, the accreditation concept, mass cancer detection, and moving the society office.

TRUMBULL

The regular monthly meeting of the Trumbull County Medical Society was held on April 20 at Trumbull Country Club. A social hour and dinner were followed by the program. Guest speakers were Dr. and Mrs. Julius Weil of the Montefiore Home for the Aged in Cleveland. Dr. Weil is executive director of the home and Mrs. Weil is director of social services.

Dr. and Mrs. Weil gave their conceptions of a well-run home for the aged. Recent articles in the *Cleveland Plain Dealer* reported work being done in the homes-for-the-aged field by the couple.

Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

CARROLL

Members of the Carroll County Medical Society entertained their wives and out-of-town guests from

Canton and Alliance at a dinner meeting held in March at the Atwood Lake Lodge, Dr. Carl A. Lincke, of Carrollton, presented an illustrated travelogue based on a recent tour of Europe by Dr. and Mrs. Lincke. Mrs. Velma Griffin, of Dellroy, provided dinner music.

TUSCARAWAS

Hart F. Page, Executive Secretary of the Ohio State Medical Association, addressed 22 Tuscarawas County Medical Society members at the regular monthly meeting last evening (March 9) at Bonvechio's.

Mr. Page, a former Midvale resident whose parents reside in RD 1, Dennison, addressed the group on the implications of Medicare and its effect on medical practice.

He also conducted a spirited discussion on their government legislation effecting medical practice.

During the business meeting, discussion was conducted on the draft law and how it will effect local physicians. — *Evening Chronicle,* Uhrichsville.

Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, M. D., ZANESVILLE)

FAIRFIELD

Members of the Fairfield County Medical Society passed a resolution at the meeting on April 12 commending The Council of the Ohio State Medical Association for its stand in regard to direct billing on the part of physicians. The action taken by The Council was at its meeting on March 20. The statement appears elsewhere in this issue of *The Journal* under the heading "Policy Regarding Governmental Medical Care Programs."

Hart F. Page, Executive Secretary of the Ohio State Medical Association, was one of the guest speakers at the meeting where he discussed the increasing importance of organized medicine in view of current developments in the medical and health fields.

James Imboden, who is stationed in Columbus as area field representative of the American Medical Political Action Committee (AMPAC), discussed developments on the political scene in view of the coming elections, and stressed the importance of backing this program.

FRANKLIN

The Academy of Medicine of Columbus and Franklin County held its annual Specialty Societies program on March 15 in the Neil House Hotel. A social hour and dinner preceded a business meeting of the Specialty Societies. Programs were presented by the Columbus Society of Anesthesiologists, Central Ohio Radiological Society, Neuropsychiatric Society of Central Ohio, and the Central Ohio Academy of General Practice.

The ninth annual joint dinner meeting of the Academy of Medicine of Columbus and the Columbus Bar Association was held at the Neil House Hotel on April 19.

Program speaker was William D. Hitt, Ph. D., chief of the Psychological Sciences Division of the Battelle Memorial Institute, who discussed automation and its applications to law and law enforcement, medical diagnosis and care, economic control, education, and work organization.

WASHINGTON

Dr. John D. Guyton, associated with the Ohio State University Department of Physical Medicine, discussed physical medicine in the general hospital at a meeting of the Washington County Medical Society. The meeting in the Lafayette Motor Hotel, Marietta, was presided over by Dr. Mary L. Whitacre, society president.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

LORAIN

Lorain County Medical Society held its Nineteenth Annual Medical Symposium at Oberlin Inn on Wednesday afternoon and evening, April 13. A total of 70 doctors of medicine and osteopaths, with interns and residents from Elyria Memorial Hospital and Lorain St. Joseph Hospital, took advantage of

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this educational opportunity. Theme of the Symposium was "Therapeutic Conference" and the interns and residents were invited as guests of the Society. President J. A. Cicerrella, M. D., welcomed all present, introducing participants, guests, and Dr. W. R. Schultz, Councilor of the Eleventh District.

Whilst the afternoon session was in progress, the wives enjoyed a conducted tour of Oberlin College Art Museum and a visit to the Intermuseum Laboratory, following which they rejoined their husbands for the social hour and dinner and the evening session. This brought the total attendance to 111.

The Symposium, arranged by the Education & Symposium Committee under the chairmanship of Rudy G. Moc, M. D., included Albert C. Lammert, M. D., James S. Hewlett, M. D., and Bruce H. Stewart, M. D., from the Cleveland Clinic, as the afternoon participants. Leonard L. Lovshin, M. D., Head of the Department of Internal Medicine at the Clinic, was the featured after-dinner speaker.

Following the social hour and dinner, Dr. J. A. Cicerrella conducted a brief business meeting. He announced that the State of Ohio Department of Health advises approval of "grant-in-aid" funds for the Uterine Cancer Detection Program currently underway under the leadership of the Cancer Committee. Dr. Bennett reported on the recent meeting of his Insurance Committee with representatives from Blue Shield of Northeast Ohio relative to the supplementary Blue Shield 65 Contracts.

John R. Peffer, M. D., of Lorain, was elected to Associate Membership in the Society, and Shan A. Mohammed, M. D., of Elyria, to Active Membership.

In the unavoidable absence of Dr. Rosenbaum, secretary-treasurer, John B. McCoy, M. D., read a Memorial Address to the late Lothar Z. Hoffer, M. D., of Lorain, and all members stood in silent tribute to the memory of their respected colleague.

Dr. Lovshin's topic on "The Surgical Mystique" was illustrated by slide presentations. In offering a vote of thanks to the team from Cleveland Clinic, Dr. Cicerrella noted how successful the Symposium had been, and how enthusiastically it had been received.

Denver, Colorado, is once again the site of the 20th Annual Rocky Mountain Cancer Conference, July 15-16, at the Brown Palace Hotel. The two-day Conference will feature some of the nation's most distinguished speakers on the subject of cancer. Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver, Colorado 80218.

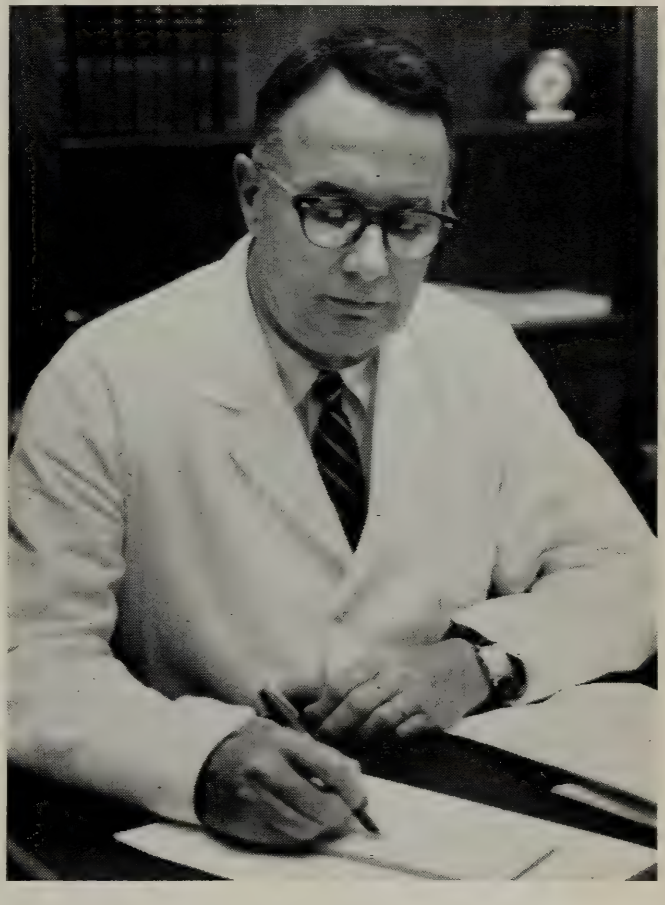
Dr. Cecil Striker, Cincinnati, was among the first rotation of physicians serving on the *S. S. Hope* during its current stay in Nicaragua. The hospital ship has been bringing modern medicine to various areas of the world since 1960.

OSU Assistant Dean Named To State Medical Board

Dr. Lloyd R. Evans, associate professor of medicine and assistant dean, Ohio State University College of Medicine, has been appointed to serve on the State Medical Board of Ohio for a term ending in 1973.

A graduate of Harvard Medical School, Dr. Evans was a fellow and house officer at Peter Bent Brigham Hospital until entering the U. S. Army Medical Corps in 1942. His rank was that of major with the 105th General Hospital (Harvard Unit) in the Southwest Pacific.

Dr. Evans served a residency at Ohio State University Hospitals in internal medicine from 1945-47. He then was a fellow of the U. S. Public Health



Service at Massachusetts General Hospital in cardiology. He was certified by the American Board of Internal Medicine in 1949.

Until joining the faculty at Ohio State in September, 1963, Dr. Evans was in private practice in Laramie, Wyoming. While in Wyoming he also was a lecturer at the University of Wyoming, a member of the Wyoming State Board of Health, commissioner of the Western Interstate Commission for Higher Education and chairman of the Rhodes Scholarship Selection Committee for Wyoming.

Dr. Evans succeeds Dr. John N. McCann, Youngstown, whose term expired.

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Three Ohioans Awarded Fellowships For Overseas Hospital Tours

Joe D. Hollingshead, a senior at Ohio State University College of Medicine, and his wife, a nurse, have been awarded fellowships which enable them to serve two months at the Garkida General Hospital, Nigeria.

Another Ohio student, Mary D. McCarthy, senior at Western Reserve University School of Medicine, will serve three months at Maria Assumpta Hospital, Ado Ekiti, Nigeria. Both fellowships are approved by the Association of American Medical Colleges and sponsored by Smith Kline & French Laboratories, pharmaceutical manufacturers.

In all, 35 American medical students were selected to receive fellowships under the program.

The OHIO STATE MEDICAL Journal

VOL. 62 JUNE, 1966 NO. 6

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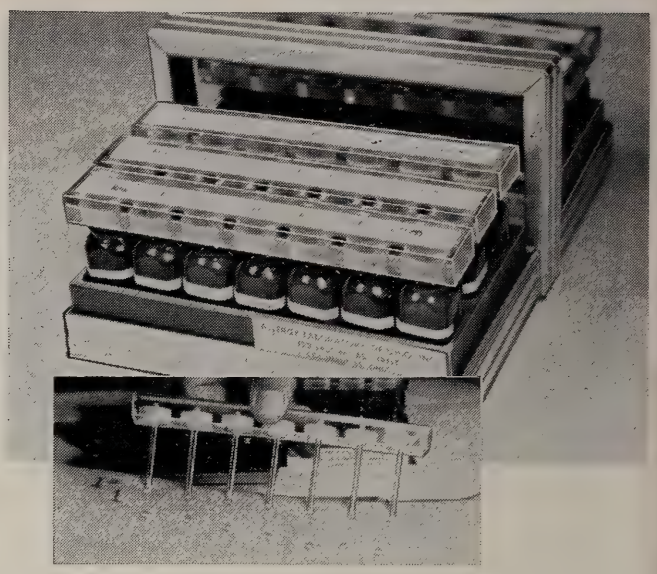
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Ohio Medical Society Executives Move to Strengthen Ties

The first annual meeting and educational conference of the Association of County Medical Executives (ACME) was held in Columbus on February 26. The meeting at the Fort Hayes Hotel was on the day preceding the Conference of County Medical Society Officers and Committeemen.

The newly formed organization is composed of members of the executive staffs of County Medical Societies in Ohio, the Ohio State Medical Association, and allied groups.

Persons attending the first annual meeting were the following:

Mrs. Patsy J. Askins, Sandusky County; John H. Austin, Stark County; Miss Jean Armour, Academy of Medicine of Franklin County; Mrs. C. K. Elliott, Greene County; Robert W. Elwell, Lucas County; Robert F. Freeman, Montgomery County, Robert A. Lang, and Donald Mortimer, Cuyahoga County;

Sidney H. Mountcastle, Summit County; Howard C. Rempes, Mahoning County; W. "Bill" Webb, Franklin County; A. Danna Whipple, Medina County; Edward F. Willenborg, Hamilton County; Hart F. Page, Charles W. Edgar, Herbert Gillen, Michael Traphagan, and Gordon Moore, OSMA headquarters; and James S. Inboden, AMPAC.

Organization of the group followed a conference held in Chicago in August of 1965 (see October, 1965 issue of *The Journal,* page 934) also attended by Ohio executive staff members. Mr. Willenborg was named president of the organization; Mr. Webb, vice-president; and Mr. Mountcastle, secretary-treasurer.

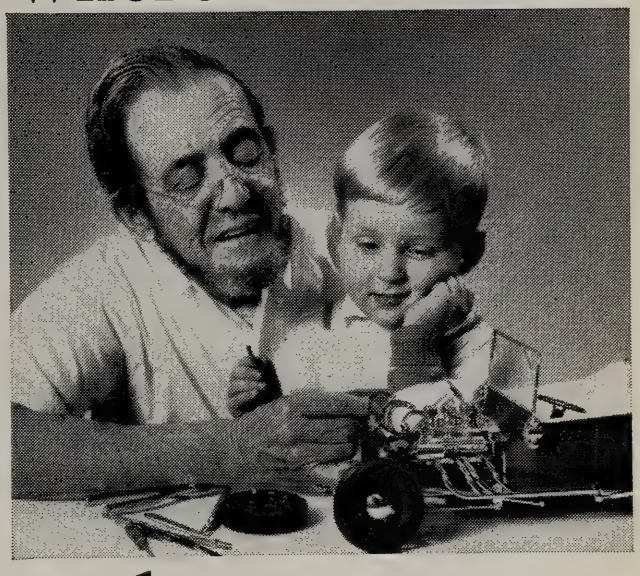
The purposes of the organization are to further the working relationship between the staffs of County Medical Societies and between organizations on the county and state levels; to discuss matters of common interest, and to develop educational programs in fields related to medical organization work in Ohio.

Members of this group have been meeting for informal discussions over a period of many years. Formation of the organization is to promote closer ties among members and to establish more definite working principles. Formation of the organization was previously approved by The Council of OSMA.

Dr. Herbert L. Pariser, Columbus, participated in the eighth annual Mental Health Workshop, "Dial M for Mental Help," presented on April 20 in Jackson, under sponsorship of the Jackson County Mental Health Association.

The Southwestern Ohio Society of Family Physicians, in collaboration with the University of Cincinnati College of Medicine, presented a seminar on "Hematology" on April 3.

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*Plotnick, M.: Int. Record of Med. 173:262, 1960.



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Health Service Student Loans and Scholarships Announced

Initial allotments, totaling $12,716,583.15 for fiscal year 1967 under the Health Professions Student Loan Program have been made to 196 schools of medicine, dentistry, osteopathy, optometry, pharmacy, and podiatry, it was announced by Surgeon General William H. Stewart, of the U. S. Public Health Service.

Allotments in Ohio include the following:

Medical Schools — Ohio State Univ., $132,075.00; University of Cincinnati, $88,656.20; Western Reserve University, $76,835.38;

Dental Schools — OSU, $132,984.30; Western Reserve, $54,103.01;

Optometry Schools — OSU, $27,000.00;

Pharmacy Schools — University of Cincinnati, $10,800.00; University of Toledo, $13,500.00;

Podiatry Schools — Ohio College of Podiatry.

* * *

Scholarship funds totaling $3,807,800 have been made available for the first time to 227 schools of medicine, dentistry, optometry, osteopathy, podiatry, and pharmacy under the new Health Professions Scholarship Program of the Public Health Service, the Surgeon General announced.

Allotments to Ohio schools were the following:

Schools of Dentistry — OSU, $30,000; Western Reserve, $13,400;

Schools of Medicine — University of Cincinnati, $20,000; OSU, $30,000; Western Reserve, $17,000;

Schools of Pharmacy — University of Cincinnati, $18,000; OSU, $14,000; University of Toledo, $5,000.

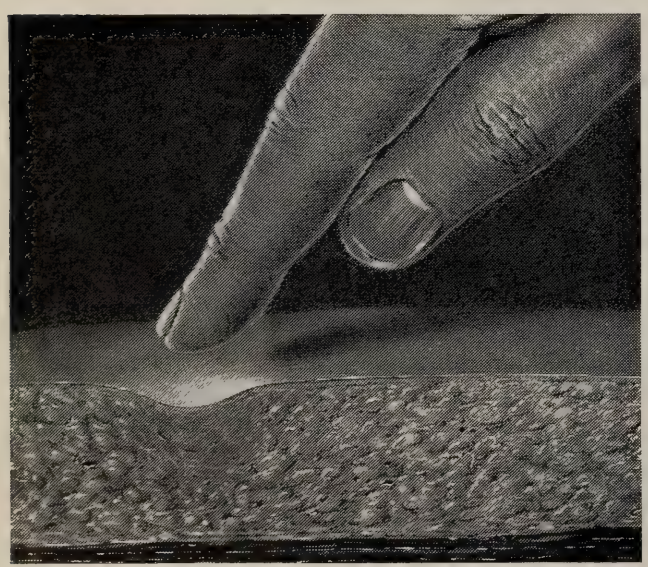
Schools of Optometry — OSU, $10,000.

Two recent medical films, produced by the motion picture division of Ohio State University's department of photography, will receive Golden Eagle Awards from the Council on International Non-Theatrical Events. They are "Kevin Is Four" film tracing the prosthetic development of an amputee child, and "The Extra-Wide Femoral Nail," sponsored by the Department of Orthopedic Surgery.

Persons interested in donating instruments, medical equipment, etc., to the Catholic medical mission field are invited to write the Catholic Medical Mission Board, Placement Service, 10 West 17th Street, New York, N. Y. 10011.

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New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during May. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

Butler
Frank C. Palmer, Fairfield
James W. Passino, Middletown
Tomas R. Yanes, Fairfield

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Larry Hipp, Granville

Lorain
Ibrahim N. Eren, Lorain

Lucas
Albert R. McKenzie, Toledo
Robert A. Louviaux, Toledo

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Thorvald W. Christiansen, Dayton
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Ottawa
George R. Korgeil, Port Clinton

Sandusky
Frank W. Ames, New York, N. Y. (Military — Home, Bellevue)

Stark
Juan A. Gallostra, Canton
Tibor Horvath, Massillon

Summit
Thomas V. Cefalu, Akron
Sanghwan Lew, Barberton
Hector J. Malave-Rosario, Akron
Leovigildo B. Reyes, Akron

November Conference on Sports Scheduled in Las Vegas

The Eighth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Las Vegas, Nevada, at Caesar's Palace on November 27, 1966. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Colonel Harold V. Ellingson, Brooks Air Force Base, Texas, commander of the USAF School of Aerospace Medicine, has retired from active military service and accepted a position as professor and chairman of the Department of Preventive Medicine at the Ohio State University College of Medicine.

The population of Ohio was 10,564,144 as of July 1, 1965, according to the Economic Research Division of the State of Ohio.

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References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.

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Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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New IRS Tax Guide Issued for Income Tax Withholdings

The Internal Revenue Service has issued a revised Employer's Tax Guide to be used in connection with the new graduated system of withholdings adopted by the Tax Adjustment Act of 1966. Provisions of new system went into effect May 1. As the IRS points out, this act makes no change in the amount of tax, merely in the amount to be withheld.

Physician-employers who have not already made this adjustment in regard to employees' withholdings, are advised to contact the nearest Internal Revenue Service office for instructions, or to consult a tax expert.

Following is an official announcement of the IRS in regard to new provisions in the law:

CIRCULAR E — EMPLOYER'S TAX GUIDE

"The Internal Revenue Service has prepared a revised Circular E, Employer's Tax Guide, containing new income tax withholding tables as an aid to employers in the changeover from Federal income tax withholding at a flat 14 percent to six rates at 14, 15, 17, 20, 25, and 30 percent. The graduated system of withholding to go [which went] into effect May 1, adopted by the Tax Adjustment Act of 1966, Public Law 89-368, was designed to link the rates at which taxes are withheld more closely with the rates which tax liability is computed.

"Henceforth, the amount of tax deducted from wages will depend not only on the amount earned and the number of exemptions claimed on the Form W-4, but also on whether a person is single or married.

"New tables in the revised Employer's Guide have been prepared for single and married employees for the following pay periods: Weekly, biweekly, semimonthly, monthly, and daily or miscellaneous. The payroll period and marital status of the employee will determine the table to be used.

As an additional service to employers, there is included in the revised Guide eight copies of Document 5642, a fact sheet for employees. Document 5642 contains information on (1) how the new tax system may affect wage withholding; (2) a comparison of weekly withholding under the old and new system, and (3) a Form W-4 to be filed with the employer.

"It is suggested that all employees study the new withholding system fact sheet carefully prior to filing a new up-to-date W-4. Employers will provide the employees with the combined fact sheet, Document 5642, and Form W-4. Persons who presently claim fewer withholding exemptions than the legal number to which they are entitled or have additional dollar amounts withheld for tax liability purposes may have too much deducted from their pay under the graduated withholding. If this is the case, individuals can increase withholding exemptions up to the legal number.

"Under the new system, married persons will be treated as single, and thus have more tax withheld, unless they file a new Form W-4 showing they are married.

"Some taxpayers, of course, primarily those with substantial nonwage income, those with two or more employers, and those whose wives work, may still want to claim fewer exemptions than the number to which they are entitled. Otherwise, they may owe tax money at the end of the year.

"For the remainder of 1966, the new system will be in effect for only 35 weeks. Consequently, taxpayers may want to consider filing a new W-4 for 1967.

"The revised guide will be [has been] mailed to all employers in April and will provide employers who have fewer than nine employees with sufficient quantities of Document 5642 for distribution.

"Special packets containing additional copies of Document 5642 will be mailed to employers with up to 255 employees. Employers with 256 or more employees (there are only 16,000 in the United States) will need to obtain their entire supply of Document 5642 from the nearest Internal Revenue Service District Office."

Stouffer Foundation Posts Award In Vascular Research Field

What is reported to be the largest medical prize in the world has been posted to track down the cause, prevention and treatment of hardening of the arteries and high blood pressure. A prize of $50,000, together with a medal and citation, will be awarded annually by the Vernon Stouffer Foundation, named for Vernon Stouffer, founder and president of Stouffer Foods Corporation.

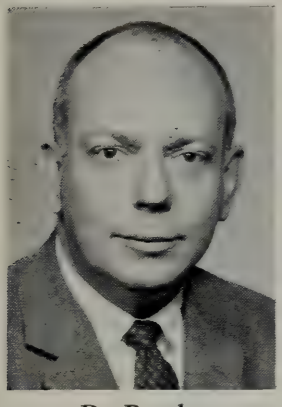
Announcement of the prize was made by Dr. Irvine H. Page, director of research at the Cleveland Clinic Foundation, and well-known authority in the fields of arteriosclerosis and hypertension.

Announcement of the prize was made at ceremonies earlier this year in Cleveland, attended by leaders in the medical and health field from all parts of the nation.

Dr. F. Mason Sones, Jr., director of the Department of Pediatric Cardiology and Cardiac Laboratory, Cleveland Clinic Foundation, was named one of ten recipients of the 1966 Awards for Distinguished Achievement in medicine given by *Modern Medicine* magazine.

Toledo State College of Medicine's First President Is Appointed

Dr. Glidden L. Brooks, of Brown University, Providence, R. I., has been appointed by the Board of Trustees as the first president of the developing Toledo State College of Medicine. The appointment becomes effective July 1.



Dr. Brooks

Dr. Brooks is director of the Institute for Health Services at Brown and associate vice-president for biomedical development. He is a native of Pawnee City, Nebraska, and graduated from the University of Nebraska in 1933. He received the M. D. degree from Harvard four years later.

From 1937 to 1941 he was on the staff of Children's Hospital, Boston, and was chief resident in pediatrics the last two years. After a year as instructor in pediatrics at Harvard he became director of pediatrics at the Central Maine General Hospital, Lewiston.

During World War II, Dr. Brooks was a commissioned officer with the U. S. Public Health Service. After the war he returned to the Lewiston Hospital as executive director. In 1949 and 1950 he was on the staff of Children's Hospital, Philadelphia, and on the faculty of the University of Pennsylvania. In addition he was director of the American Academy of Pediatrics committee for the improvement of child health. Subsequent appointments include those at the University of Pittsburgh as professor of hospital administration, association professor of pediatrics, and coordinator of hospitals and clinics.

Before going to Brown, he was medical director of the United Cerebral Palsy Associations.

Opinion on Medical Treatment for Ohio Youth Commission Wards

A recent opinion of Attorney General William B. Saxbe states that the Ohio Youth Commission "not only has the authority but has an affirmative duty to order routine and emergency medical treatment for children committed to its care when such is required."

The following communication from Daniel W. Johnson, chairman of the Ohio Youth Commission, gives the commission's policy in this regard as well as a summary of the Attorney General's opinion:

"In response to questions raised by several juvenile courts, we requested an Attorney General's Opinion to determine the necessity for obtaining Medical Waivers from parents of children committed to the Ohio Youth Commission. Opinion No. 66-045 was received on February 25, 1966, and states, in summary, the following:

"1. The Ohio Youth Commission not only has the authority but has an affirmative duty to order routine and emergency medical treatment for children committed to its care when such is required. Section 5139.01 (A)(3) and (A)(4), Revised Code.

"2. This authority relates equally to temporary and permanent commitments. Section 5139.05 (B), Revised Code.

3. Consultation with parents is frequently desirable and should be encouraged. However, no formal waiver from parents or Juvenile Courts in lieu thereof is required. There is judicial authority for ordering medical treatment for children over objections by parents and guardians. *In re Clark,* 21 0.0. 2d 86; 30 A.L.R. 2d 1138.

"As a consequence of the above opinion, we have decided to discontinue the practice of requesting of Juvenile Courts to submit medical waivers at the time of commitment, effective March 1, 1966."



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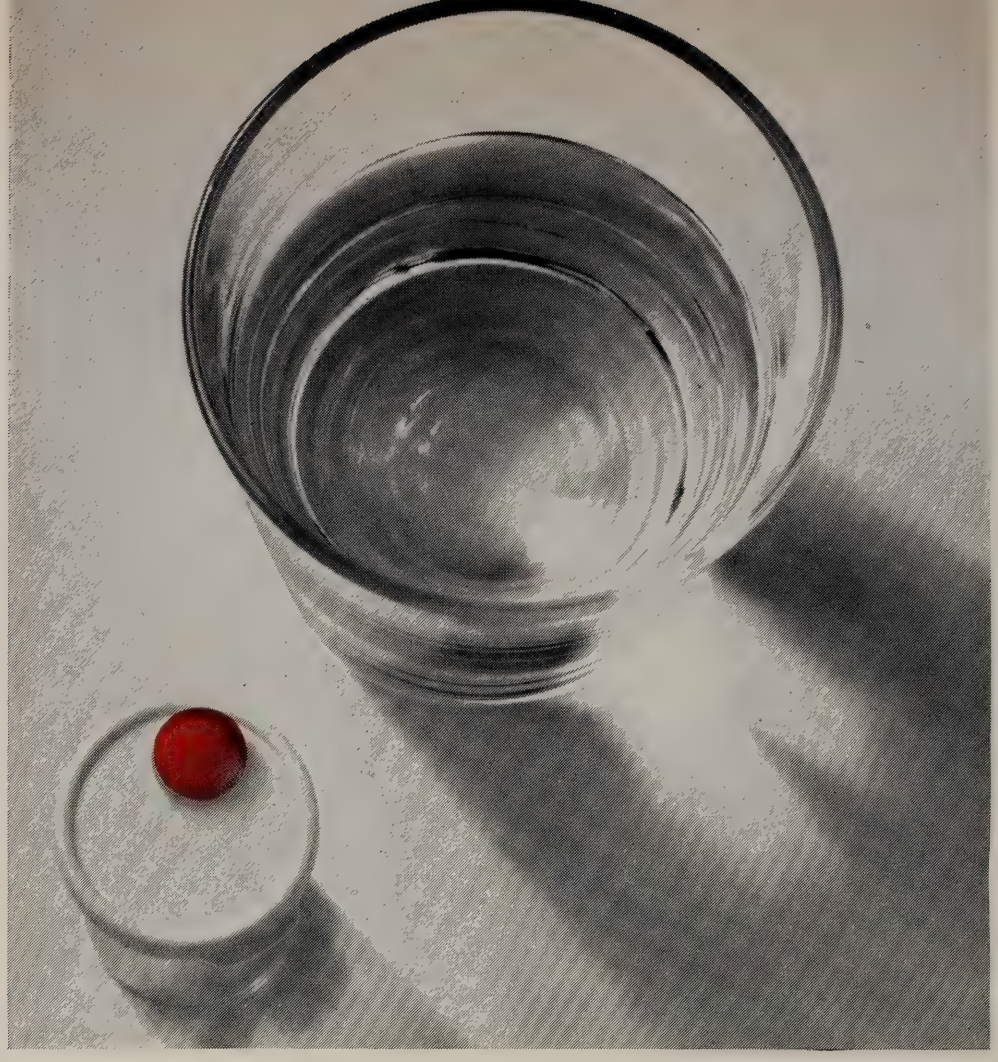
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Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Sm amounts of drug and short exposure may produce an exaggerat sunburn reaction which may range from erythema to severe sk manifestations. In a smaller proportion, photoallergic reactio have been reported. Patients should avoid direct exposure to su light and discontinue drug at the first evidence of discomfort.
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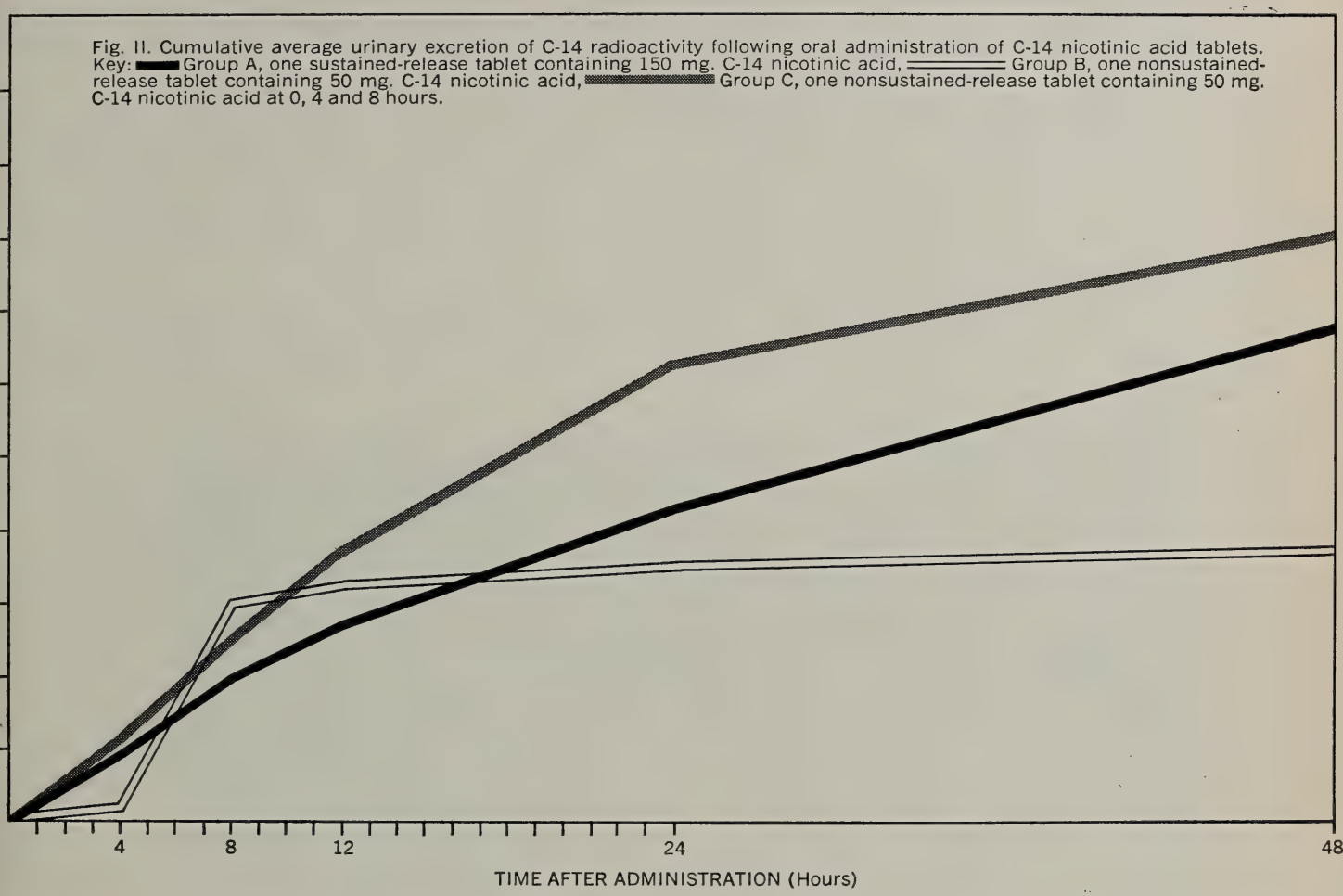


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

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A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Health Referral Service in Ohio for Selective Service Rejectees

THE Ohio Department of Health and more than 125 local health departments in Ohio have joined with the United States Public Health Service and with other state and local health departments throughout the country in a new program to assist individuals who are rejected by Selective Service or Armed Forces enlistment for medical reasons.

Dr. E. W. Arnold, director of the Ohio Department of Health, described the new Health Referral Service as filling a long-felt need for special services to the large number of young men being rejected for military service because of failure to meet medical standards. He pointed out that about half the young men called for military duty have failed pre-induction examinations, and about half who failed were disqualified for medical reasons.

Interviewers Stationed

Under the new program, the Ohio Department of Health has placed nurse-interviewers at the three Ohio Armed Forces Examining and Entrance Stations in Cleveland, Columbus, and Cincinnati. Counseling and advice to the rejectees starts at these stations with agreement of the rejectees. Interviews are confidential and medical information is released only with authorization of the individuals.

When medical care or corrective procedures are indicated, the individual is referred to the appropriate medical resources in his home community. Details are forwarded from the Health Referral Service at the state level to the designated participating agency on the local scene.

Follow-up contact is made with the rejectee at home to assist him in obtaining the medical aid he needs. This may start with his family physician and go on to include additional special services. If the rejectee needs financial help, he is advised about agencies that offer such help. The project does not interfere with the private doctor-patient relationship in the community, but rather tends to improve and promote this relationship, sponsors declared.

Federal Grant Backing

This program was first recommended by a Presidential Task Force on Manpower Conservation in 1964. Pilot studies indicated that a large percentage of rejectees had remediable conditions, but were not aware either of the conditions or the remedies in many cases. Congress acted to provide grants through the United States Public Health Service to state and local health departments to establish the new Health Referral Service.

Ultimate aim of the Health Referral Service is to obtain medical help for all medically disqualified young men who have been rejected for military service and to ascertain through follow-up whether these young men are continuing under appropriate medical care.

Supervising the Health Referral Service in the Ohio Department of Health is Dr. Ralph D. Lausa. He is serving on a part-time basis and maintaining his private practice in the City of Columbus.

Grant Will Promote Nursing Program At WRU and University Hospitals

John S. Millis, president of Western Reserve University, and Stanley A. Ferguson, director of University Hospitals, recently announced the receipt of a $216,140 five-year grant from the W. K. Kellogg Foundation.

The funds will be used to effect a major change in the relationship between WRU's Frances Payne Bolton School of Nursing and the Department of Nursing at the Hospitals.

The reorganization will promote greater integration of all nursing activities in the University Medical Center.

In effect, this move means that faculty members, who to date concentrated their efforts on education, will also have responsibility for patient care. Conversely, nurses who formerly directed their efforts mainly toward patients will assume a more active role in educating students.

School of Allied Medical Services To Be Established at OSU

The Ohio State University College of Medicine will establish a school of Allied Medical Services July 1, according to an announcement from the university.

Degrees to be offered through the school will be a bachelor of science in medical dietetics, medical illustration, medical technology, occupational therapy and physical therapy. Certificates will be awarded in medical technology, nurse anesthesiology, orthoptic technology and physical therapy.

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Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

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Western Reserve Medical School Gets Substantial Sears Gift

University Medical Center, in Cleveland, and the Case Institute of Technology, jointly announced gifts of $1 million each from Lester M. and Ruth P. Sears. Mr. Sears is honorary chairman and founder of Towmotor Corporation.

The gift of $1 million for Western Reserve University School of Medicine is the largest received to date from a private individual source by the University Medical Center Development Program. It will be used for the construction of the Administration Tower which is part of the planned addition of the School of Medicine. It will be named the Lester M. and Ruth P. Sears Administration Tower.

The tower will be the focal point between the existing School of Medicine and the planned East Wing. Rising five floors above the Health Science Schools' Podium, it will serve as the main traffic artery between the two buildings.

It will house the dean's offices, administrative offices, conference rooms and meeting areas. The main entrance to the tower will be at the Podium level, directly opposite the Health Science Schools' Library.

The University Medical Center Development Program, which seeks $54.8 million for the Schools of Medicine, Dentistry and Nursing of WRU and the University Hospitals of Cleveland, was announced four years ago.

Construction has already begun on two projects. The $11 million Bishop Building, which is the Hospitals' general patient service unit, is scheduled for completion this year. The $2.5 million Hanna House addition was begun last fall and is to be completed in 1967.

To date, the UMC has received $33 million and land is being cleared along Abington and Cummington Roads to permit construction of the five-acre Health Science Podium. The five-floor East Wing of the School of Medicine, which will be connected to the present building by the Sears Administration Tower, will contain the Health Science Schools' Library, medical students' classrooms, conference rooms and laboratories.

* * *

The Trustees of Case Institute of Technology have chosen to honor Mr. and Mrs. Sears by naming the largest academic building on the Case campus, The Lester M. and Ruth P. Sears Library-Humanities Building. Their names will grace the building which dominates the Case campus and forms the west entrance to the entire University Circle area.

The gift allows the institute to pursue its goal of excellence in engineering and scientific education. Since its opening in 1961, the Library-Humanities Building — which is ultimately designed to hold 250,000 books — has become a center of intellectual life on the Case campus, providing study space for 446 students.

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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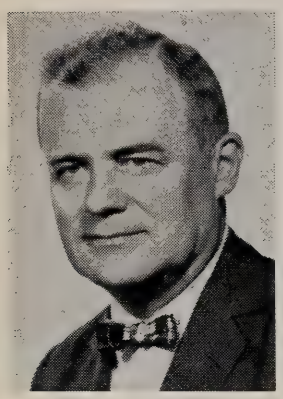
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Dean of Medical School Named At Western Reserve

Newly appointed dean of Western Reserve University School of Medicine is Dr. Frederick C. Robbins, professor of pediatrics at the medical school and director of the Department of Pediatrics and Contagious Diseases at Cleveland Metropolitan General Hospital. Announcement of the appointment to become effective September 1 was made by Dr. John S. Mills, Western Reserve president.



Dr. Robbins

Dr. Robbins was awarded the Nobel Prize in 1954 for his share in development of a method of growing polio virus cultures in the laboratory, an achievement credited with setting the stage for development of polio vaccine. He shared the honor with Dr. John F. Enders and Dr. Thomas H. Weller, his colleagues at Harvard during the research period.

Born in Auburn, Ala., Dr. Robbins received two bachelor's degrees from the University of Missouri and his medical degree from Harvard, where he graduated in 1940.

He moved to Cleveland in 1952 as chief of pediatrics at City Hospital, now Metropolitan General. From 1958 to 1962 he was chairman of the Committee on Medical Education at Western Reserve. In 1964 he was named director of the perinatal center of the hospital.

Dr. Robbins succeeds Dr. Douglas D. Bond, who several months ago announced his plans to retire to devote full time to teaching and research.

Dr. William E. Barratt, Painesville, recently participated in a tour of service with Project Viet-Nam.

What To Write For

Some booklets, pamphlets, and other published materials available for the asking or at nominal expense and suitable for the physician's office, library or waiting room or for his personal information.

* * *

For Good Dental Health, Start Early. A leaflet for parents of young children, particularly those in the preschool years. National Dairy Council, 111 N. Canal Street, Chicago, Illinois 60606.

* * *

Mental Health of Children. This report provides an overview of the child program of the National Institute of Mental Health, with a sampling of specific projects and programs. Public Health Service Publication No. 1396; for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402; price 40 cents.

* * *

AMA Health Education Materials—Catalog. A listing of numerous posters, pamphlets, etc., for patient education with prices. Available from the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

* * *

Mental Health in Appalachia; Problems and Prospects in the Central Highlands. "This summary, a departure from the usual type of conference report, represents an effort to distill the essence of a meeting rather than report verbatim details. It has sought to capture the gist of this discussion of a region's mental health problems, and reflect the insights and perspectives of experts familiar with the region, as helpful background for meaningful planning of mental health services." Public Health Service Publication No. 1375. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402; price 15 cents.

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OSMJ Scientific Section

VOL. 62 JUNE, 1966 NO. 6

Birth Defects Registry

Evaluation of a New Program in Cincinnati

CHRIS HOLMES, B. A., KENNETH I. E. MACLEOD, M. D., M. P. H.,
and WINSLOW BASHE, M. D., M. P. H.

IN OCTOBER 1964, a Birth Defects Registry was inaugurated by the Health Commissioner of Cincinnati. The primary purpose of this Registry is to obtain a base line incidence value for birth defects occurring in the Cincinnati area. The project is following in its broad outlines — but with considerable modification — a similar five-year study in Birmingham, England, reported by McKeown and Record.[1] One significant difference between the two studies is in the spectrum of defects on which information is desired. The Birmingham study selected the defects in which they had special interest, whereas Cincinnati's project includes all defects, functional as well as structural, from the major, life-threatening or crippling congenital malformations to the seemingly unimportant birth anomalies. Thus, while the Birmingham report ruled out such defects as pigmented nevi and congenital umbilical hernia, the Cincinnati study includes these.

At present the main sources of data for the Cincinnati study are: (1) Hospitals; (2) Birth Registry; and (3) Death Registry. These sources report their information on Birth Defect Cards, which are then sent to the Cincinnati Health Department (see Fig. 1). All eleven hospitals in the Cincinnati area which have maternity beds are participating in the Registry program. Hospital record room personnel review each newborn chart, and from the neonatal physical examination a Birth Defect Card is sent if there is any evidence of such a defect. In addition, there is a place on the Ohio Birth Certificate where the physician is to check a box "yes" or "no" for the presence of a "congenital malformation." No information about the type of malformation present is demanded on the birth certificate, and this part of the certificate is regarded as confidential; it is never, for example, duplicated when a record of birth is sent to a family. A member of the Hamilton County Vital Statistics Office reviews each month's birth certificates and sends a Birth Defect Card to the Health Department for every case where "congenital malformation" is marked "yes." Information about the type of defect present must be supplied either by a phone call to the hospital or by reference to a duplicate defect card sent from the hospital — if one is present.

There is a similar method of reporting defects which appear on Death Certificates. Each month a member of the Vital Statistics Office reviews all the deaths for that month. On any certificate where the primary or contributory cause of death has been ascribed to a birth defect, a Birth Defect Card is sent to the Health Department. These cards taken from

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the death certificates do, of course, contain information about the type of defect present, unlike the cards from the birth certificate.

In addition to these three major sources of data there are two others, one of which is not yet operational, and one of which is designed for follow-up study. Beginning in September, 1965, a pre-entrance examination of school children, organized by the Cincinnati Health Department, will be established in the Cincinnati area. It is hoped that this examination will dislose those defects which do not become evident until some years after birth. Finally, in order to obtain more information about a particular, selected case, a Long Form protocol has been created. The information asked for on this form covers maternal history, delivery history, immediate neonatal problems, defects in previous children and other pertinent information. Answers to these questions are to come from newborn and maternity hospital charts. By agreement between the Cincinnati Health Department and Cincinnati area physicians, no family contact will be made by Health Department personnel for follow-up purposes without the M. D.'s knowledge and permission.*

At the time of writing this report, the Birth Defect Registry has been operational for 10 months. The purpose of this report is to point out some of the problems related to the Registry after the first seven operational months, to evaluate the efficiency and the effectiveness of the different reporting systems, and possibly to offer methods for improving the program.

Methodology

First, a birth defect rate (B. D. R.) was calculated for each hospital.

$$\text{B. D. R.} = \frac{\text{Total Birth Defects}}{\text{Total Live Births}} \times 100/\text{Given Unit of Time.}$$

These rates were calculated on a monthly basis and for the overall seven month period. Since the B.D.R.'s varied considerably from month to month, only the results of the seven month B. D. R. are expressed. It was noticed that the B. D. R. of one hospital, Cincinnati General Hospital (C.G.H.), was consistently higher than all the other hospitals. The question immediately arose whether this difference was a real one (that is, due to some difference in hospital population, obstetric procedures, etc.) or whether it was a reflection of a failure in hospital reporting of birth defects. And if the latter case were true, was this a failure of reporting all defects, or were there particular types of defects not being reported? Were, for example, only major defects being reported to the neglect of minor ones?

To answer these questions, several techniques were employed. First, arbitrary parameters of "major" and "minor" birth defects were defined from a list of the types of defects received for the seven month period. This list was cumulated, categorized, and is expressed in Tables 1 and 2. Then, using the parameter "minor" defect, the number of minor defects reported by each hospital was calculated and expressed as minor defect percentages of total defects for each

TABLE 1. *Table of Cumulated Total Minor Defects*

System or Category	Examples	Number of Defects
Cardiovascular System	Hemangioma	16
Genitourinary System	Hydrocele, Hypospadias, Cryptorchidism, Imperforate Hymen, Fusion of Labia Minora, and others.	77
Gastrointestinal System	Tongue-tie, umbilical hernia, inguinal hernia, and others.	41
Head and Neck	Bronchial cleft cysts, salivary cysts, accessory auricle, mal-development of pinna, nasal deviation, obstructed tear duct, scalp defects, pre-auricular sinus or tags and others.	54
Thorax and Abdomen	Supernumerary nipple, inverted nipple, pilonidal sinus or dimple, and others.	30
Extremities	Syndactyly, digital tags, simian creases, and others.	20
Defects involving Pigmentation	Lentigenes, vitiligo, mongoloid spots, pigmented nevi, and others.	24

*N. B.:Some patients become known to the Department by a separate system — the Handicapped Registiy.

CINCINNATI HEALTH DEPT. BIRTH DEFECTS REGISTRY

CHILD..... SEX..... COLOR .....

RESIDENCE ..... MOTHER'S NAME .....

BIRTHDATE..... BIRTHPLACE..... B. C.#.....

DATE OF DEATH..... PLACE..... D. C. #.....

BIRTH DEFECT PRESENT..... SUSPECTED..... HOSP. CASE NO.....

MAJOR SYSTEM, OR SYSTEMS, AFFECTED .....

DEFECT:.....

DIAGNOSING PHYSICIAN.....

CHILD REFERRED TO:.....

SIGNATURE OF PERSON REPORTING DEFECT.....

(If more room is needed for reporting, use reverse side)

FIG. 1. *Card Form Used for Reporting Birth Defects*

TABLE 2. *Table of Cumulated Total Major Defects*

System or Category	Examples	Number of Defects
Cardiovascular System	Septal defects, transposition of great vessels, tetralogys of Fallot, Thrombocytopenia, Erythroblastosis fetalis, Hemolytic disease of the newborn, and others.	65
Neuromuscular System	Anencephaly, Arnold-Chiari Malformations, Meningoceles, Myelomeningoceles, Hydrocephalus, Foot drop, Microcephaly, Macrocephaly, absence of muscles anywhere, Paralysis anywhere, and others.	59
Respiratory	Diaphragmatic defects, T.E.F.'s, Respiratory Distress syndrome, congenital cystic pulmonary malformations, and others.	33
Genitourinary System	Chardee, Duplication of Cervix and uterus, Hydronephrosis, cystic kidneys, and others.	11
Gastrointestinal System	Chalasia, Rupture of a Viscus, malrotation of viscera, Imperforate anus, congenital meconium ileus, cleft lip, palate or alveolar ridge, other body anomalies, and others.	21
Bone Defects and Extremities	Osteogenesis Imperfecta, Synostosis, Hemivertebrae, Hyperplasia or Hypoplasia of an extremity, Tight hip adductor syndrome, Torticollis, Polydactyly club foot, Scoliosis, Pectus excavatum, Dislocatable hip, and others.	91
Biliary System	Hypobilirubinemia, hyperbilirubinemia, Biliary atresia, Hepatosplenomegaly, and others.	9
Special Senses	Lack of sight, Lack of ear canal, congenital cataracts, and others.	4
Chromosomal Defects	Mongolism and Turner's syndrome.	15
Neoplasm	Papillomas, Lipomas	6

hospital. Next, three hospitals with low B. D. R.'s were sampled to determine the efficiency of the hospital reporting system. The sample was 134-150 newborn charts in size, and the names of the newborn were randomly taken from December 1964 Birth Certificates. The charts of these newborn were reviewed, and noted were any cases where defects were present but not reported. New after-sample B.D.R.'s and minor defect percentages were then calculated.

The other two reporting systems, Birth Certificates and Death Certificates, were also evaluated. First, an effort was made to see what per cent of the Defect Cards came from each reporting system and how many duplicate cards there were for each system. Then, all Birth Certificates and Death Certificates from the Hamilton County Vital Statistics Office for the month of December, 1964 were reviewed, and noted were any defects present on these certificates which were not reported by Vital Statistics Office personnel.

Next, an effort was made to look at Stillbirth Certificates. The Stillbirth Certificate, like the Death Certificate, has a place to indicate the presence of a birth defect. This certificate must be completed on all stillbirths who are older than 20 weeks gestation. Since the Stillbirth Certificate was not one of the Health Commissioner's original sources for birth defects, there was no established routine in the Vital Statistics Office for reporting them. It was felt, however, that a potential source of defects was being missed. And, since the stated purpose of the Registry was to look at all defects, those in stillbirths — like those in neonatal deaths—should have been included. Therefore, all stillbirths from Hamilton County for the period October 1, 1964 to April 30, 1965 were reviewed, and those indicating a defect were noted. Also noted was the number of duplicate defect cards from hospitals for this period which indicated a defect in a stillborn.

Finally, to evaluate the Long Form as an instrument for follow-up, five cases from each of eight hospitals were selected for a follow-up study to see how much of the information requested by the Long Form was obtainable from hospital charts alone.

Data

(See accompanying Tables and Figures)

Discussion and Results

Before and After-Sample of Hospital Charts

Fig. 2 and Fig. 3 show the data for the calculated before-sample B.D.R.'s and minor defect percentages

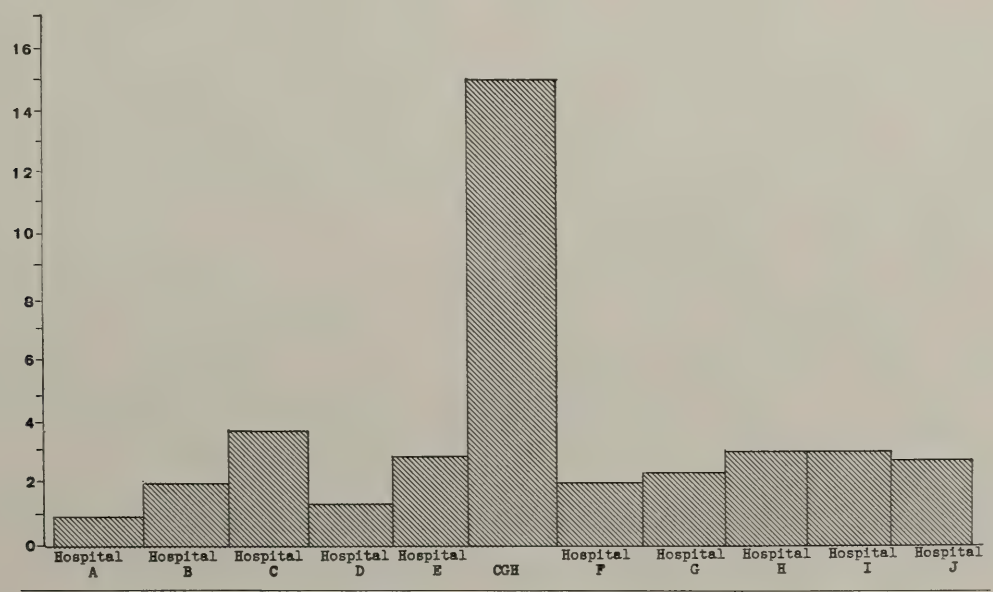


FIG. 2. *Birth Defect Rate (%), October 1, 1964 - April 30, 1965.*

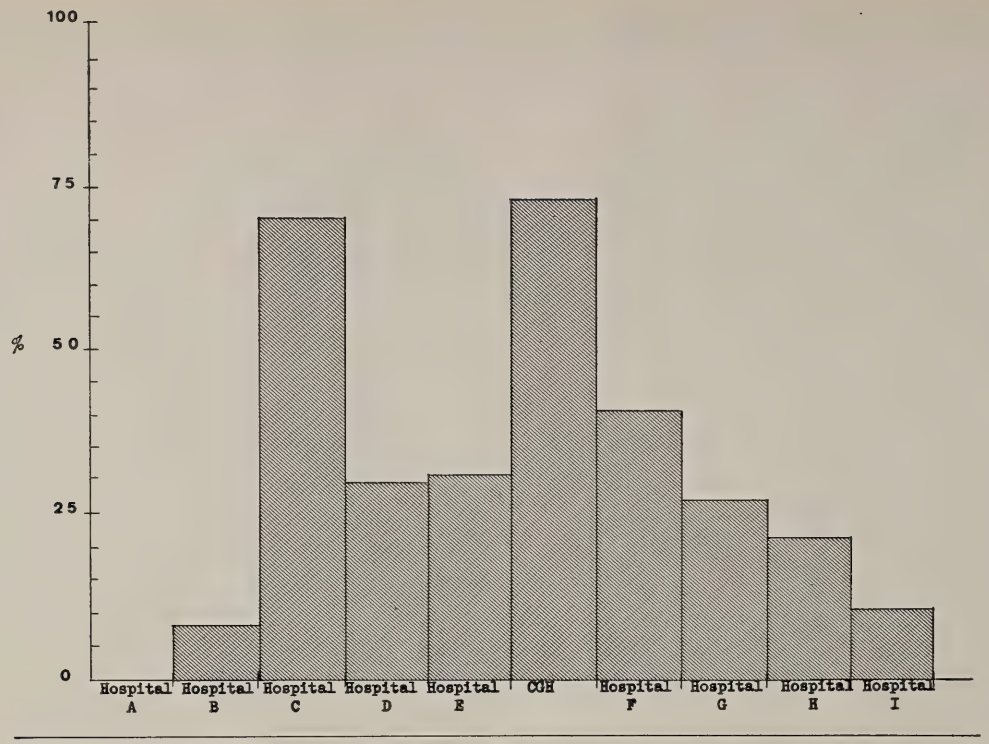


FIG. 3. *Total Minor Defects as % of Total Defects, October, 1964 - April 30, 1965.*

for the seven month period. In both cases Cincinnati General Hospital (C.G.H.) stands out above the other hospitals, although hospital D approaches it for reporting of minor defects. Table 3 shows the results of the sample of newborn charts from the hospitals selected. In all three cases both the B.D.R.'s and the minor defect percentages were considerably greater in the sample. C. G. H. was, itself, not sampled, and it is possible that there are still defects lying unreported from this hospital for the month of December. But it still seems safe to conclude that one important reason for the difference in B. D. R.'s between C.G.H. and the other hospitals is a simple lack of reporting. This failure in reporting partially involves reporting of minor defects, since this type of defect was definitely increased in the sample. But since the after-sample minor defect percentages were considerably less than 100 per cent (43 to 65 per cent), it is not just a lack of reporting minor defects which is the problem. Rather the basic problem seems to be a simple lack of reporting of all birth defects in general, major or minor.

TABLE 3. *Comparison of Birth Defects Identified in a Sample of Hospital Records and Birth Defect Cards. Four Selected Hospitals, Cincinnati, December, 1964*

	Hospital A	Hospital D	Hospital I	C. G. H.
Total Live Births For December, 1964	335	488	221	
Total Newborn Charts Reviewed	134	135	150	
Total Defects Found	16	19	20	
Calculated Birth Defect Rate Before Sample for 12/64	.89%	1.2%	2.7%	12.8%
Calculated Birth Defect Rate After Sample for 12/64	11.8%	14.0%	13.3%	
Number of Minor Defects	7	12	6	
Minor Defects Percentages of Total Defects Before Sample for 12/64	0%	0%	36%	60%
Minor Defects Percentages of Total Defects After Sample for 12/64	43%	63%	65%	

Comparison of The Three Major Reporting Systems

Table 4 is a comparison of the three major reporting systems. Theoretically, if the Birth Certificate as a source of information were 100 per cent effective

TABLE 4. *Comparison of Three Reporting Systems October 1, 1964 - April 30, 1965*

	Hospital Cards	Birth Certificates	Death Certificates or Death Indicated on Defect Cards from Hospitals
Duplicated Cards (From Hospital and Birth Certificate or from Hospital and Death Certificate)	28	20	8
Unduplicated Cards (From Hospital with no Duplicates from Birth Certificate or Death Certificates)	380	0	17
Unduplicated Cards (From Birth Certificate or Death Certificate with no Duplicates from Hospitals)	0	28	65

there should be an equal number of duplicate defect cards from both the hospitals and the birth certificate, since presumably the hospital chart room fills out a card for every birth defect and the physician present at birth checks the box marked "congenital malformation" on the birth certificate. Actually, of 400 Birth Defect Cards from Hamilton County hospitals and Hamilton County Birth Certificates combined, 380 were from the hospitals with only 20 duplicates from the birth certificates, which clearly indicates how poor the birth certificate is as a source of information. But, there were also 28 cards from the birth certificate which had no duplicates from the hospitals. Therefore, although reporting on the birth certificate is poor, it is a necessary supplement as long as hospital reporting remains poor.

Table 4 also gives the data on Death Certificates as a source of defects. Of 90 defect cards which indicated a death, 65 were from the death certificate, 17 from hospitals and eight were duplicates from both these sources. This indicates (1) that the death certificate is an important source of defect information, and (2) that, again, the hospitals are reporting poorly defects in live births and neonatal deaths.

Sample of Birth and Death Certificates

Table 5 gives the data from the one month sample of all Birth and Death Certificates from the Hamilton County Vital Statistics Office. Nine birth certificates

TABLE 5. *Sample of Birth and Death Certificates for December, 1964*

	Birth Certificates	Death Certificates
Birth Certificates with "congenital malformation" checked yes or Death Certificate with birth defect indicated	9	24
Cards sent by Vital Statistics	8	12

were found which had "congenital malformation" checked "yes"; eight defect cards were sent by the Vital Statistics Office for that month. Twenty-four death certificates were found with defects indicated; 12 defect cards were sent by the Vital Statistics Office for that month. Therefore, the Birth Certificate reporting system is much more efficient than the Death Certificate system.

Efficiency and Effectiveness Ratios

The terms "efficiency" and "effectiveness" have been used several times in this report. Table 6 is an attempt to give statistical significance to these terms for the three major reporting systems. Efficiency is a measure of the internal functioning of a reporting system; efficiency ratios were calculated (1) for the three hospitals sampled by dividing the before-sample birth defect rate by the after-sample birth defect rate, and (2) for the birth and death certificates by dividing the number of Birth Defect Cards sent from the Vital Statistic Office by the number of defects actually found in the birth and death certificates after the one-month sample.

TABLE 6. *Efficiency and Effectiveness Ratios for Three Reporting Systems (as %)*

	Efficiency Ratio (%)	Effectiveness Ratio (%)
Hospital Cards	7.5 to 20.3 (For Three Hospitals Sampled)	77
Birth Certificates	88	5.9
Death Certificates	50	79

Effectiveness is a measure of what each reporting system contributes to the over-all program; effectiveness ratios were calculated for the hospital cards and the birth certificates by dividing the total number of unduplicated cards received from each of these sources by the total number of unduplicated cards received from all sources combined. For the death certificate the calculations were slightly different, since we were measuring defects in deaths here, not in live births. The effectiveness ratio for this reporting system was calculated by dividing the total number of unduplicated defect cards received from the death certificate (65) by the total number of unduplicated cards received from all sources which had death indicated on them (82). Thus, while the Death Certificate contributes only a small amount to the total program (65/490 = 13 per cent), it does contribute a large percentage of what can be expected from it (79 per cent).

It can be seen in Table 6 that the hospital card is a very effective source (that is, it contributes greatly to the program), but it is very inefficient; only a small amount of defects are being reported by this system. The Birth Certificate is a highly efficient source, but its effect on the program is very small. The Death Certificate is moderately efficient and highly effective, contributing a large percentage of the information on defects occurring in deaths.

Discussion of Some of The Registry's Problems

While the primary purpose of this report was to point out some of the Registry's problems, there was also an attempt made to understand why these problems arose. People involved in all aspects of the program were talked with; hospital record room personnel, employees of the Health Department and the Vital Statistics Office, and some few local physicians. No concrete answers are forthcoming, but some impressions were formed which should be discussed here.

One of the problems with hospital reporting seems to be a general misunderstanding of what is actually wanted by the Registry. It is true that enthusiasm for the program ranged the spectrum from highly enthusiastic and helpful to a can't-be-bothered-with-your-problems attitude, but in those hospitals where interviews (more informal chats, really) were made, there was often only a vague awareness of what the program demanded. Did the Commissioner of Health

really want ALL defects, even the really minor ones, even those in neonatal deaths? Another problem is that hospital chart room personnel cannot be expected to know medical terminology, and in many cases they didn't seem to realize that a pigmented nevus, for example, was considered a birth defect for the purposes of this program, as was erythroblastosis fetalis (erythro what?). Finally, information on hospital charts can turn up in unexpected places (not to mention many cases of illegible penmanship) and can be difficult enough even for a physician to find; for a person who is not medically trained, who doesn't really know what she is looking for, or where to look for it when it is not where it is supposed to be, the problems become very great.

The problems with the Birth Certificate system are even more enigmatic. The efficiency of this source is very high, but the effectiveness is very low. Therefore, whoever is responsible for filling out the medical information of the birth certificate — presumably the physician attendant at birth — is not doing so. Part of this problem may lie in a misunderstanding of the phrase "congenital malformation." Just where does one draw the line between a congenital malformation and a birth defect, or a birth anomaly, or a congenital anomaly? Another aspect of the problem seems to lie in the desire of some physicians to protect their patients from some stigma which might occur if the patient's defect was put on public record. Although this position is legally untenable, it might have some basis in medical ethics if the birth certificate were, in fact, a public record. Actually, only people who present good reasons for doing so are allowed to look at these files, and, as has already been mentioned, the portion of the Birth Certificate which contains the medical information is never duplicated when records of birth are sent to families.

The problems with the Death Certificates may be simpler ones. Of the 12 death certificates with defects for the month sampled which were not reported by the Vital Statistics Office, three were transpositions of the great vessels and two were hemophiliacs. The other seven were more randomly distributed across the spectrum of defects. The consistency with which these defects were missed suggests that one reason for this failure of reporting is due, once again, to a lack of a medical vocabulary on the part of Vital Statistics Office personnel — a failure to appreciate that transpositions of the great vessels and hemophilia are defects which should be reported.

Stillbirth Certificate

There were 185 Stillbirth Certificates for the eight month period of October 1, 1964 to May 30, 1965. Twenty-one defects were found. There were no duplicate cards from the hospitals which indicated a defect in a stillborn. The number of Stillbirth certificates each month is very small, and the time required to review these certificates for the presence of defects — by a Vital Statistics Office employee — would also be small. And, while the total amount of information which this source could contribute would be less than the other sources, the stated purpose of the Birth Defect Registry is to obtain information on all defects, including those causing or contributing to death. Whether the death is neonatal or prenatal should not make any difference. Therefore, it is concluded that the Stillbirth certificate should be included as another source of defects.

Long Form Evaluation

Table 7 gives the data on the evaluation of the Long Form as an instrument for follow-up study of selected cases. The actual data from the Form itself have been distributed into nine categories for their expression in this table. For example, "complications in the first trimester" may have been infectious disease, trauma, irradiation, diabetes or other surgical procedures. In some categories information was almost always available from the hospital charts. The length of labor, length of gestation, type of delivery, complications of delivery, cyanosis in the newborn, the presence of toxemia symptoms or vaginal bleeding in the immediate prepartum period were usually present in maternal or newborn charts. This seemed to be because the established routine of charting obstetric and newborn care required such information on the maternal history and physical examination, the delivery room records, the newborn physical examination or elsewhere. But other very important information, such as the presence of birth defects in previous births, is practicably unattainable from the hospital charts. This seems to be because nowhere on the chart was such information requested.

TABLE 7. *Long Form Evaluation*

Number of Newborn Charts looked at (with corresponding maternal charts)	40
Number of charts showing a previous live birth	29
Number showing a birth defect in a previous live birth	1
Number of charts showing a previous stillbirth	0
Number of charts showing abortions	10
Number of charts showing complications in first trimester	9
Number of charts showing complications in second trimester	8
Number of charts showing immediate prepartum and delivery history	29
Number of charts showing infant prenatal and natal information	40

In one case of a woman who had delivered two previous children with congenital eye deformities and had just delivered a third child with the same deformity, there was no mention anywhere in the maternal chart of the previous children's deformities, although the present child's deformity was noted on his newborn chart. This information on the previous two children was found out only by a chance phone conversation with the family pediatrician.

Conclusions

Several conclusions can be drawn from this study:

(1) Hospital reporting of birth defects is poor.

However, at least one hospital, Cincinnati General, has shown that a high level of performance is possible. Since the hospitals are the most important source of information, the performance of C.G.H. must be imitated by the other hospitals if the purpose of the Registry is to be realized.

(2) The Birth Certificate contributes relatively little to the program. Some of the problems with this source have been pointed out; the solution to these problems is probably at present unattainable. However, this source must be continued as long as hospital reporting remains poor.

(3) The Death Certificate is an effective source of birth defects in neonatal deaths. This source must be maintained as long as hospital reporting of defects in neonatal deaths remains poor.

(4) The Stillbirth Certificate should be included as a source of defects, for reasons already given.

(5) The Long Form as an instrument for follow-up study is only partially successful. Much important information, particularly that relating to defects in earlier births, is not practicably available in the hospital charts. This information would not become available unless the charting procedures were modified or unless family interviews were made by Health Department personnel; the former condition is very unlikely, and the latter condition is more or less prohibited by agreement between the Health Department and local physicians.

Reference

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RUBELLA. — A controlled prospective inquiry regarding mothers who had rubella during the first 16 weeks of pregnancy was begun during 1950-2. Three follow-up medical examinations of the children resulting from these pregnancies were carried out, the first at 2 years (259 children), the second between 3 and 6 years (237 children), and the third between 8 and 11 years (227 children).

Follow-up of the infants showed that when rubella occurred during the first 16 weeks of pregnancy the incidence of congential abnormalities in the children was significantly raised. When the infection occurred after the 16th week the incidence of abnormalities in the children of the rubella mothers was no higher than in the controls.

This paper reports the final outcome of the inquiry, with special reference to the findings of the three examinations.

Major abnormalities, mainly of the eye, ear, and heart, occurred in 15 per cent of the children, 8 per cent having more than one abnormality. Minor abnormalities were present in a further 16 per cent, 4 per cent having more than one abnormality. These are outside estimates, as it is possible that some of the abnormalities discovered were due to causes other than maternal rubella.

It has been suggested that rubella children often show emotional instability and difficult behaviour, but although the information was specifically requested there was little supportive evidence in the reports. Twelve children were variously noted as "shy," "immature," "lacking in concentration," or "liable to outbursts of temper," but only one, a blind child, was reported as "psychologically difficult." The distribution of intelligence among the children was normal.

The need for long-term follow-up and periodic full reassessment of children known to be at risk from maternal rubella during the first 16 weeks of pregnancy was clearly demonstrated. — Mary D. Sheridan, M. A., M. D., D. C. H., *British Medical Journal,* 2:536-549, August 29, 1964.

Polycystic Liver Disease

Report of a Case Employing Needle Biopsy And Liver Scanning

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THE EARLY identification of polycystic liver disease is difficult. Only when the cysts and associated hepatic enlargement become palpable is clinical detection possible. Combined use of radioisotope scanning and directed percutaneous needle biopsy has been recommended in the diagnosis of localized lesions.[1,2]

This report illustrates the diagnostic changes in liver scans which were obtained before and after needle biopsy and aspiration of fluid from hepatic cysts.

Case History

A 50 year old white man entered the hospital on June 11, 1965, with a chief complaint of severe right upper quadrant pain of sudden onset, but gradually lessened over several days of observation in the hospital. There was no associated fever and no other symptoms. No previous history of similar complaint was elicited. Past history revealed a severe chronic anxiety state. The patient had received a course of electro-convulsive therapy for depression one year ago.

Physical examination revealed moderate right upper quadrant tenderness on deep palpation. No abdominal masses, organ enlargement, or other abnormalities were detected. Temperature and other vital signs were normal. The admitting diagnosis was possible acute cholecystitis but convincing evidence of peritoneal irritation was not detected.

Laboratory Studies: White blood cell count was elevated to 13,800 per cubic millimeter with a differential count of 84 per cent polymorphonuclear cells, 11 per cent lymphocytes, and 1 per cent eosinophils on the day of admission. The following day and subsequently both the white blood cell count and the differential count were repeatedly normal. Hematocrit, urinalysis, icterus index, and serum levels of alkaline phosphatase, proteins: albumin and globulin, and amylase were normal.

BSP retention was 2 per cent at 45 minutes. The one-stage Quick-prothrombin time was 17 seconds with a control of 14 seconds. Radiologic studies, including a chest film, abdominal scout film, intravenous pyelogram, gallbladder series, barium enema, and upper gastrointestinal series, were all within normal limits. A liver scan was obtained (Fig. 1). This revealed scattered negative defects. The most prominent area of abnormality was in the inferior aspect of the anterolateral portion of the right lobe. Differential diagnosis included metastatic tumor and multiple hepatic abscesses.

A percutaneous, transthoracic hepatic biopsy was performed on June 22, 1965. The needle was directed anterolaterally. Upon withdrawal of the obturator of the Vim-Silverman needle, a clear colorless fluid was observed and a total of 15 ml. was collected. With the usual technique a small amount of biopsy material was obtained from the liver and the procedure was terminated. The tissue obtained at biopsy revealed no histologic abnormality. Analysis of the fluid revealed less than 1.0 Gm. per 100 ml. of total protein, occasional red blood cells per high power microscopic field and no evidence of parasites or other organism. Bacteriologic culture and cytologic study of the fluid was negative. A repeat liver scan (Fig. 2) was obtained five days after the hepatic biopsy. This revealed an almost complete disappearance of the previously observed negative defect on the anteroinferior margin of the right lobe. It was learned at this point that the patient's mother had undergone biliary tract surgery 15 years previously because of an attack of the right upper quadrant pain. Polycystic liver disease was the sole abnormal finding at that operation.

Comment

Polycystic liver disease is rarely symptomatic. Symptoms, if they appear are usually observed in the fourth and fifth decades of life. Upper quadrant abdominal pain is the most common presenting complaint.[3] The health of the patient is mainly influenced by associated polycystic disease of the kidney or other anomalies such as aneurysm of cerebral arteries. Typically, there are no laboratory hepatic function abnormalities.[4] Cysts mainly arise from the anteroinferior surface of the right lobe of the liver and thus are quite accessible to percutaneous needle biopsy. The chief importance of early diagnosis in polycystic liver disease is to prevent unnecessary laparotomy.

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Summary

The disappearance of a previous liver scan defect was observed after puncture and aspiration of fluid from an area of localized multiple hepatic cysts. The combined use of liver scanning and directed needle biopsy-aspiration as illustrated here, is a valuable tool in the early diagnosis of polycystic liver disease.

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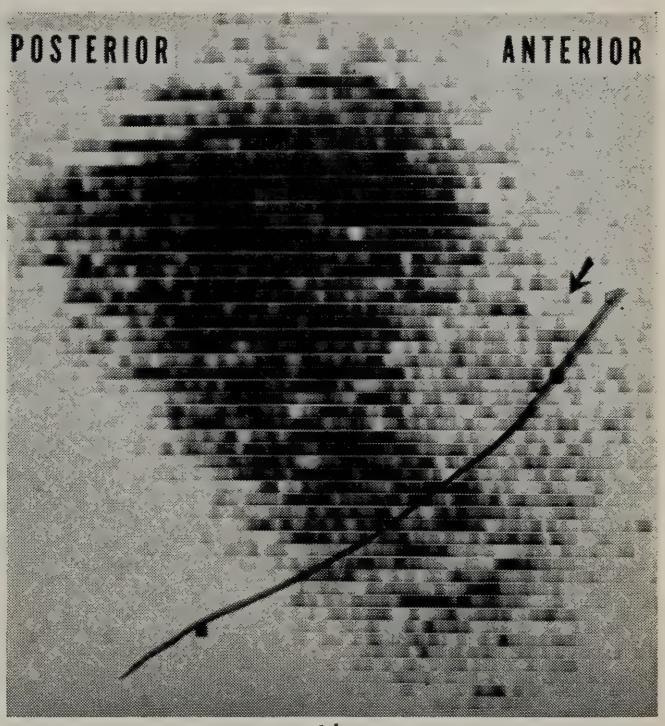
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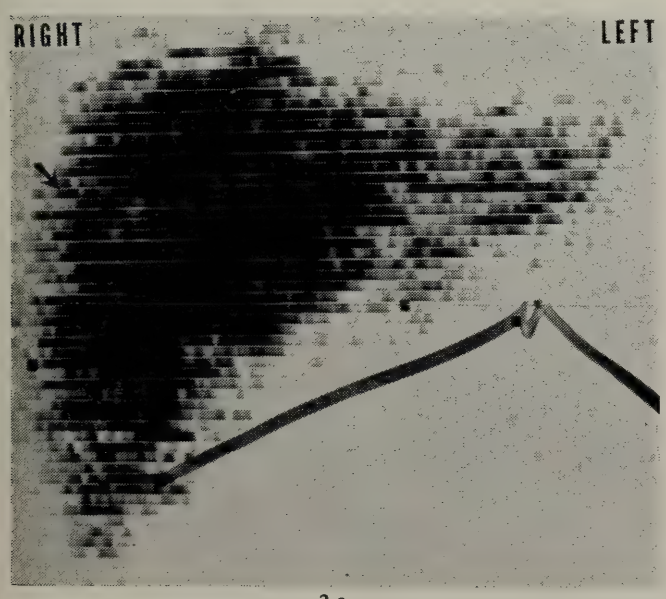


1-a



1-b

FIG. 1. (a) *and* (b). *Anterior and Lateral liver scans revealing scattered negative defects. Arrows indicate the area of maximal abnormality in the anterolateral aspect of the right lobe.*



2-a



2-b

FIG. 2. (a) *and* (b). *Repeat anterior and lateral liver scans obtained following puncture and aspiration of fluid from hepatic cysts. Arrows indicate the areas of disappearance of previously marked negative defect.*

Liver Biopsy

A Report of Experience in 151 Cases

C. JOSEPH CROSS, M.D., WILLIAM A. MILLHON, M.D., JUDSON S. MILLHON, M.D., and DONALD E. HOFFMAN, M.D.

THE practice of puncture and diagnostic aspiration of the liver has been recognized as a valuable aid in the analysis of liver dysfunction for many years, yet there remains a reluctance on the part of many physicians to use this procedure. In reviewing a relatively small series obtained over a two-year period in a private hospital, we found that it was an extremely helpful diagnostic aid in over 40 per cent of the cases. With recognition of the contraindications, it is felt that needle biopsy should be performed more frequently. These contraindications are well documented and include:

(1) Uncooperative patient
(2) Low prothrombin time
(3) Local infection
(4) Ascites
(5) Intense extrahepatic obstructive jaundice
(6) Severe anemia
(7) Prolonged bleeding from skin at time of biopsy

METHOD

One hundred and fifty-one liver biopsy specimens were submitted to the Riverside Methodist Hospital, Pathology Department, between April, 1961, and December, 1963. Sixty-four of these biopsies were obtained at laparotomy and showed no significant histopathologic abnormalities. These were predominantly needle biopsies taken at the time of elective biliary tract surgery and will not be considered in our discussion. The remaining 87 liver biopsies are made up of two major groups, including: (1) 43 percutaneous liver biopsies and (2) 44 open liver biopsies showing significant abnormalities.

Percutaneous Needle Biopsy

The 43 percutaneous needle biopsies of the liver were obtained in the majority of instances with the Vim-Silverman needle. The Menghini needle and the Franklin modification of the Vim-Silverman needle were also used.

The specimens obtained have been considered to be a positive aid in diagnosis in 56 per cent of cases (24 cases) and to be of no aid in diagnosis in 44 per cent of cases (19 cases). These figures compare favorably with those obtained in much larger series. The biopsy was considered to be a positive aid if it confirmed (11 cases) or corrected (13 cases) the clinical diagnosis. Normal liver tissue, liver tissue with negligible alterations, or an inadequate specimen were the reasons for considering biopsies of no aid in diagnosis. Two biopsy specimens showed nondiagnostic pathologic changes. One of these was from a patient who ultimately died with Hodgkin's disease. The other was from a patient who later had wedge biopsy at laparotomy with the diagnosis of granulomatous liver disease, probably sarcoidosis.

The types of clinical diagnoses confirmed or corrected by needle biopsy include a variety of disease entities. Nearly all known clinical applications of this procedure are represented by the following case studies.

(A) Cirrhosis in various stages of activity and degrees of severity has been demonstrated. Biopsy of the cirrhotic liver has proven valuable both in the observation of the natural course of the disease and in determining the effectiveness of therapy.

Case 1

A 45 year old white man was admitted with chronic easy fatigability. He had been hospitalized 18 months previously with diarrhea and had been found to have ascites, hepatomegaly, and laboratory studies indicative of active nutri-

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tional liver disease. He admitted to a moderately heavy ethanol intake over a period of several years. During the 18-month interval between his first and present admission, he had stopped drinking. Present laboratory data included prothrombin time 52 per cent of normal; alkaline phosphatase 10.6 units; total protein 6.7 grams with albumin 2.8 Gm. and globulin 3.9 Gm.; serum glutamic oxalacetic transaminase 83 units; cephalin cholesterol flocculation 2 plus; and bromsulfalein retention, 15 per cent at 45 minutes.

COMMENT: The liver profile was thought to be characteristic of cirrhosis.[8] The impression was supported by a percutaneous needle biopsy of the liver which showed active portal cirrhosis. Intensification of appropriate medical management in this case was based on the demonstration of unsuspected active liver disease.

(B) The purely diagnostic use of liver biopsy in an unsuspected case of cirrhosis is illustrated by the following example.

Case 2

A 55 year old nurse developed hepatosplenomegaly. She had noted a sensation of fullness in the upper abdomen and a tendency to bruise easily. There was a history of rheumatic heart disease with chronic congestive heart failure since the age of 48 years managed successfully with digitalis and diuretics. The liver was palpable 6 cms. below the right costal margin. There was no history of jaundice, biliary tract disease, or alcoholism. Numerous diagnostic possibilities were considered. Laboratory data included hemoglobin 12.4 Gm. per 100 ml.; white blood cell count 2,500 per cu. mm. with 61 per cent neutrophils, 5 per cent eosinophils, and 33 per cent lymphocytes; prothrombin time 44 per cent of normal; total protein 6.7 Gm. with albumin 3.9 Gm. and globulin 2.8 Gm.; cholesterol 138 mg.; alkaline phosphatase 15.4 units; cephalin cholesterol flocculation 4 plus; thymol turbidity 13.2 units.

Needle biopsy of this patient's liver disclosed active postnecrotic cirrhosis of the liver and chronic cholangitis.

COMMENT: The diagnostic efficiency of needle biopsy in cirrhosis was worked out by Braunstein with the aid of postmortem sampling.[6] He determined that in cases of nutritional cirrhosis the diagnostic accuracy was 100 per cent. Cirrhosis secondary to hepatitis and liver necrosis may be recognized with approximately 96 per cent accuracy.

This patient ultimately died in hepatic coma with massive ascites and liver failure. She was considered to have postnecrotic cirrhosis, presumably secondary to nonicteric hepatitis, the more common form of viral hepatitis and an occupational hazard in this patient's profession.

(C) Percutaneous biopsy has also been helpful in detecting intrahepatic neoplasm.

Case 3

A 60 year old white woman was admitted with complaints of weakness and a sensation of fullness in the upper abdomen. Her liver was palpable 7 cm. below the right costal margin with a smooth and firm edge. Chest x-rays, an upper G. I. series and a cholecystogram were reported negative. A barium enema revealed a suspicious finding in the region of the hepatic flexure, but air contrast follow-up studies were not remarkable. Liver function studies were abnormal. Laboratory data included prothrombin time 77 per cent of normal; alkaline phosphatase 11.1 units; total protein 6.8 grams with albumin 4.6 Gm. and globulin 2.2 Gm.; total bilirubin 0.7 mg. with direct acting 0.0 mg.; serum glutamic oxalacetic transaminase 19 units; cephalin cholesterol flocculation negative; thymol turbidity, 1.5 units; and bromsulfalein retention, 19 per cent at 45 minutes.

The patient was suspected of having cirrhosis because of a history of ethanol ingestion and the findings of hepatomegaly and altered liver functions. Percutaneous liver biopsy in this patient demonstrated metastatic adenocarcinoma.

COMMENT: One series has been reported concerning liver biopsy on patients subsequently shown to have intrahepatic neoplasm. The needle biopsy was 74 per cent accurate.[7] Another notes that metastatic neoplasms of the liver are identified in 80 to 90 per cent of established cases.[5]

Case 4

A 67 year old white male alcoholic was admitted with light icterus and weakness. Four years prior to this admission he had undergone exploratory laparotomy and open liver biopsy that revealed cirrhosis. Presently the liver was noted to be enlarged 4 cm. and to have a firm irregular and slightly tender margin. Laboratory data included bromsulfalein retention 35 per cent at 45 minutes; serum glutamic oxalacetic transaminase 238; total protein 6.1 Gm. with albumin 2.6 and globulin 3.5; total bilirubin 2.1 mg. and direct 1.3 mg.; alkaline phosphatase 57.8 units; and cephalin cholesterol flocculation 2 plus.

Percutaneous liver biopsy was interpreted as hepatoma.

(D) The biopsy has also been employed in a reciprocal manner, i. e., to demonstrate nodular cirrhosis in a patient suspected of having metastatic carcinoma in the liver.

Case 5

A 63 year old widowed white woman was admitted with jaundice, ascites, weakness, and anorexia. A multinodular and indurated liver was palpable 8 cm. below the right costal margin. The gallbladder was also thought to be enlarged and indurated. Laboratory data included prothrombin time, 37 per cent of normal; total protein, 5.0 with albumin 2.7 Gm. and globulin 2.3 Gm.; thymol turbidity, 2.6 units; total bilirubin, 12.2 mg. and direct bilirubin, 8.2 mg.; alkaline phosphatase, 13.9 units; serum glutamic oxalacetic transaminase, 138 units; and cephalin cholesterol flocculation 1 plus.

Percutaneous needle biopsy of the liver showed nodular cirrhosis of the liver.

(E) The distinction between medical and surgical jaundice has been facilitated by means of liver biopsy.

Case 6

A 66 year old white man was admitted two months after cholecystectomy for cholelithiasis and empyema of the gallbladder. He had received whole blood transfusions at surgery. His hospital course during the current admission was characterized by recurrent jaundice over a period of several weeks. Serum bilirubin, alkaline phosphatase, and enzyme levels fluctuated widely. Controversy existed regarding the differential diagnosis of intermittent common duct obstruction from stone or stricture as against "medical jaundice." Percutaneous liver biopsy was performed twice and each was interpreted as showing "hepatitis." The patient eventually died with acute fulminating pancreatitis. No extrahepatic obstruction to bile flow existed.

COMMENT: The histologic diagnosis of viral hepatitis by needle biopsy has been reviewed extensively by Smetana.[3] He terms it the only single method which permits an unequivocal diagnosis of acute nonfatal hapatitis. Not only may the histologic picture be seen to change with the stage of the disease, but also the occasional persistence of active hepatitis may be determined.

Conversely, extrahepatic obstructive jaundice requiring surgical intervention is represented by the following case study.

Case 7

A 60 year old white man was admitted with anorexia and jaundice. He gave a history of chills, fever, and jaundice for three weeks preceding his admission. He had had a cholecystectomy for cholelithiasis seven months previously. The liver was enlarged 3 cm. and was tender. Laboratory data included total bilirubin, 5.4 mg. and direct bilirubin, 3.2 mg.; alkaline phosphatase, 14.0 units; serum glutamic oxalacetic transaminase, 42 units.

The diagnosis of extrahepatic obstructive jaundice and cholangitis was made. Percutaneous biopsy showed diffuse increase in bilirubin pigmentation in the liver cells. Small

bile thrombi were present in the canaliculi. There was no evidence of cholangitis. The patient was operated upon and a stricture of the common bile duct was repaired. Subsequently the liver function studies have reverted to normal and the patient has done well.

(F) Another clinical application of percutaneous needle biopsy has been the exclusion of hepatic disease in apparent hepatomegaly.

Case 8

A 54 year old white woman was admitted for evaluation of hepatomegaly. Physical examination had disclosed descent of the liver margin below the level of the iliac crest. Her liver function studies were within normal limits.

Percutaneous needle biopsy disclosed normal liver tissue with fibrous capsular tissue present at both ends of the biopsy fragment, suggesting the presence of a Riedel's lobe.

Open Liver Biopsy

Liver biopsy performed at laparotomy undoubtedly provides the more accurate method of sampling liver lesions, especially isolated lesions. Laparotomy not only permits visualization of the liver surface but also an opportunity to obtain a larger biopsy specimen.

Forty-four open liver biopsies considered in this study were reported as showing significant histopathologic abnormalities. The liver biopsy itself was the only operative procedure performed in 32 (72 per cent) of these patients.

Twenty-five of the 44 patients upon whom open liver biopsy was performed were noted to have palpably enlarged livers preoperatively. Twenty-one of these 25 patients (80 per cent) had no operative procedure other than liver biopsy at laparotomy.

DISCUSSION

Numerous articles on percutaneous needle biopsy of the liver indicate that it is a clinically useful procedure.[1] There are many practical advantages of needle biopsy, including simplicity of the apparatus, minimal expense and patient preparation, performance at the bedside, and minimal patient discomfort.

The value of needle biopsy over wedge-resection has been questioned by some authors due to the small size of the specimen. However, the deeper specimen obtained from the needle will not neglect the nonspecific distortion common in the immediate subcapsular areas, or those induced by surgical trauma, and the specimen obtained is large enough that even gross inspection can be of diagnostic help.[9]

Complications of the needle biopsy procedure include hemorrhage into the peritoneum, which is the chief fatal complication. Zamcheck reported a mortality of 0.17 per cent after reviewing 20,016 needle biopsies performed since 1907.[2] Our limited series of 43 percutaneous needle biopsies include one apparent complication, that being a self-limited hemorrhage in a patient with a history of a bleeding tendency.

Needle biopsy is clearly not indicated in all cases of liver disease. Enthusiasm for its use should not serve as a substitute for a complete clinical and laboratory investigation. Once obtained, the biopsy specimen may fail in interpretation. This is especially true in the lack of distinction between primary biliary (cholangiolitic) cirrhosis and portal or even postnecrotic cirrhosis.[5] Similar difficulties are encountered in differentiating obstructive jaundice from chronic parenchymatous jaundice. Perhaps newer methods of evaluation of the liver cells will help to eliminate these problems of differentiation.[4]

Percutaneous needle biopsy of the liver has, however, proven helpful in a certain limited number of cases. It is suggested that one area in particular in which the needle biopsy might be considered favorably, rather than resorting to open liver biopsy, is in the diagnosis of metastatic malignant tumor in the liver that is palpably enlarged.

Summary

(1) One hundred and fifty-one liver biopsy specimens have been studied. These include 43 percutaneous biopsies and 44 open liver biopsies showing significant histopathologic abnormalities.

(2) Percutaneous liver biopsy has proven to be a positive aid in diagnosis in 56 per cent of cases in which it was employed.

(3) Percutaneous biopsy is useful in a diverse group of diseases of the liver and biliary system.

(4) The liver biopsy itself was the only operative procedure performed in 72 per cent of the open liver biopsies showing histopathologic abnormalities. These studies should have been performed by percutaneous liver biopsies.

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Diagnosis of Obscure Splenic Cyst By Aortography

A Case Report

CHARLES D. HAFNER, M.D., AND MAJID A. QURESHI, M.D.

THE PATHOLOGY of nonparasitic splenic cysts was classified by Fowler[1] in 1953, and more recently, the signs and symptoms have been summarized by the authors.[2,3] While the majority of symptomatic splenic cysts will clearly suggest the correct diagnosis, which then may be readily confirmed by routine methods of roentgenology, an occasional splenic cyst may lie in obscurity and make definitive diagnosis quite difficult. Many newer and more sophisticated roentgenographic examinations have been advocated in recent years for this condition, but to our knowledge, the use of aortography has not been employed to demonstrate any of the 563 splenic cysts recorded to date in the literature.

The present case report is an example of an obscure symptomatic splenic cyst, the diagnosis of which was established by retrograde femoral catheter aortography which visualized the splenic vasculature. This report further suggests the use of aortography in the differential diagnosis of other elusive intra-abdominal conditions such as pancreatic cysts, carcinoma of the pancreas, gastrointestinal angina, neoplasms of the spleen, kidneys and adrenal glands, and other retroperitoneal tumors.

Case Report

A 45 year old woman was admitted to the hospital with the chief complaint of left upper abdominal pain and discomfort of two years' duration, with progression in severity of symptoms over the three months prior to admission. The pain was quite vague and poorly described. However, it was primarily localized in the left upper quadrant and was frequently precipitated by the ingestion of a medium to large meal. The patient had the sensation of "food hanging at a point, then going past that point," at which time she obtained relief. Because of this postprandial discomfort, she had resorted to more frequent smaller meals and avoided larger ones. In addition, she experienced fairly severe pain in the left lower chest and upper abdomen after walking two to three city blocks. When this occurred, she was required to sit down and rest until the pain subsided. Occasionally, the discomfort radiated to the left shoulder and left posterior chest. At times she experienced aching discomfort in the upper mid-dorsal back, posterior cervical area and occipital region. This was attributed to long-standing rheumatoid arthritis for which she had been receiving steroid therapy. There had been no history of injury or pancreatitis.

Physical examination revealed a pale, thin, chronically ill white woman in no acute distress. Physical examination was negative, except for a very soft bruit audible over the mid-epigastric region.

Laboratory investigation revealed a normal complete blood count and urinalysis. Gastrointestinal roentgenograms, intravenous pyelograms, and chest films were normal. Plain views of the abdomen revealed a small area of calcific density in the left upper quadrant, which the radiologist had interpreted as a possible splenic artery aneurysm. A retrograde femoral catheter aortogram was performed, and this revealed a figure-of-eight tortuosity in the splenic artery, but no aneurysm. The angiogram did reveal, however, a distortion of the primary branches of the splenic artery into a cup-shaped deformity outlining a splenic mass (figure 1). A

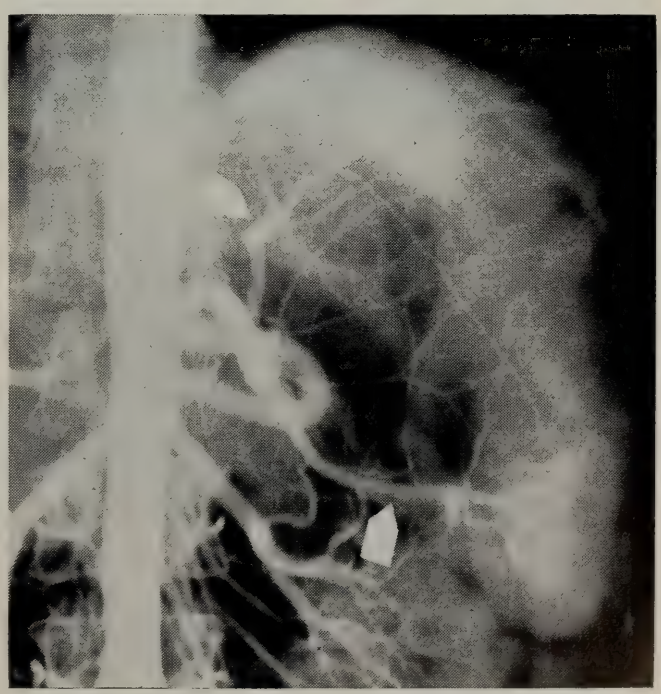


FIG. 1. *Splenic cyst outlined by angiography.*

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small rim of normal splenic tissue at the periphery was outlined by the resulting splenogram in the later exposures of the serial angiogram. No parenchymal tissue was seen, however, in the hilar area where the splenic arterial branches were displaced. This together with calcification led to the diagnosis of a splenic cyst.

At the time of operation, a large cystic mass was found to be replacing most of the spleen, which was about five times the normal size.

The resected gross specimen is seen in Figs. 2 and 3. The microscopic sections revealed hyalinization and calcification in the wall of the cyst. This probably represented a secondary splenic cyst resulting from a hematoma, although the etiology is not completely clear.

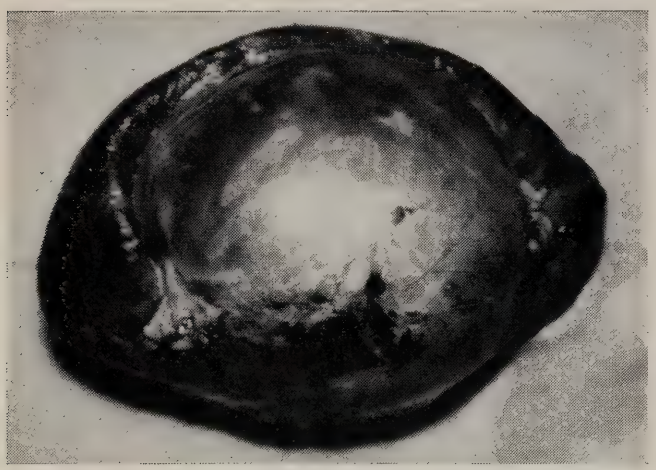


FIG. 2. *Large cyst of spleen.*



FIG. 3. *Transected gross specimen of splenic cyst.*

Her postoperative course was uneventful and she has been completely relieved of her symptoms. No longer having a fear of eating, she has gained in weight and strength, and has been completely rehabilitated.

Discussion and Conclusions

There was no evidence of preoperative secondary hypersplenism in this case. Only rarely has hypersplenism associated with a splenic cyst been reported in the literature, and this combination, when present, has usually been considered coincidental. In addition, there was no postoperative thrombocytosis which is frequently seen following splenectomy. Thus, removal of this spleen caused no physiological alterations. This probably is explained by the fact that very little functioning splenic tissue remained because of the encroachment by the cyst.

Many splenic cysts may be asymptomatic and only discovered coincidentally at the time of surgical removal or at autopsy. When splenic cysts attain a certain size, they usually become symptomatic and present a variety of symptoms.[3] The diagnosis may be readily suggested by the clinical picture and easily confirmed by the routine roentgenographic methods. However, an occasional symptomatic splenic cyst may be quite difficult to diagnose, as exemplified by the present case report. When routine measures fail to reveal the diagnosis in obscure intra-abdominal conditions, it is suggested that aortography be considered.

Of the 563 splenic cysts reported in the literature to date, none has been diagnosed by angiography. The catheter method of aortography is preferable to the translumbar approach, since the level of injection may be altered, thereby permitting selective visualization of the aortic branches. Serial exposures using a rapid cassette changer should be employed.

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CEREBRAL INFARCTION. — One hundred and thirty-four patients with a clinical diagnosis of cerebral infarction were studied; 71 had a diastolic blood pressure below 110 mm. Hg and 63 a diastolic pressure of 110 mm. Hg or above. The former group presented a picture of a large cortical and subcortical lesion and showed a high incidence of stenotic and occlusive lesions at angiography; the degree of recovery was poor. The latter group presented a picture of a small deeply situated lesion. There was a low incidence of arteriographic lesions and the patients were left with little disability. The importance of distinguishing between these two groups is stressed. — John Prineas, M. D., and John Marshall, M. D., London, England: *British Medical Journal,* 1:14-17, January 1, 1966.

Bilateral Congenital Lumbar Hernia

BENJAMIN W. BUTLER, M. D., and ALAN D. SHAFER, M. D.

A LUMBAR hernia is a parietal wall defect rarely seen by the practicing surgeon. It is the third rarest of hernias with only the perineal and sciatic hernia being more rare. Historically the first authentic case was described at autopsy by Garangeot. Petit in 1783 anatomically described a strangulated hernia through the space which now bears his name. In 1866 Grynfeltt described a second point of exit for lumbar hernia. A lumbar hernia may present either through the superior triangle of Grynfeltt or through the inferior triangle of Petit.

Lumbar hernias are classified as being either congenital or acquired. Acquired lumbar hernias include defects in the lumbar region secondary to trauma, inflammation or herniation through a congenital weakness. A congenital lumbar hernia manifests itself at or shortly after birth and is not uncommonly associated with other muscular defects due to its etiology on the basis of mesodermal arrest.

Our case is one of congenital bilateral hernia with an associated eventration of the right diaphragm. In reviewing the anatomy of the lumbar region, several points are noted which illustrate reasons for the rarity of the congenital lumbar hernia.

Anatomy

In the lumbar area two triangles are described. These are the superior triangle of Grynfeltt and the inferior triangle of Petit (Fig. 1). The superior triangle is bounded above by the twelfth rib and the serratus muscle, anteriorly by the posterior border of the internal oblique muscle, and posteriorly by the anterior border of the sacrospinalis muscle. The floor is formed by the transversus abdominis muscle and fascia. This triangle is much more common; however, herniation through it is rarer according to Harkins.[8]

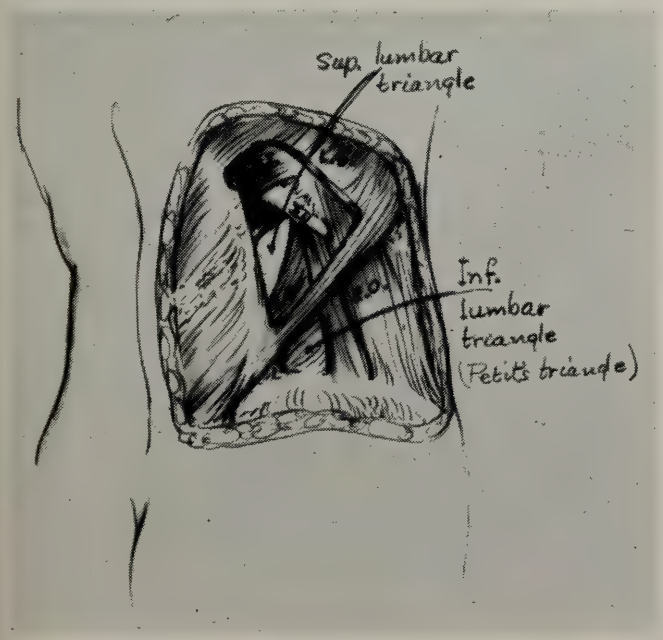


FIG. 1. *Surgical Anatomy*

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Petit's triangle, by contrast, is not always present, and according to Lesshaft[10] it is present in less than 25 per cent of infant cadavers. The floor of the triangle is formed jointly by the internal oblique, the lumbar fascia, and the transversus abdominis. It is bounded anteriorly by the posterior border of the external oblique, inferiorly by the crest of the ilium, and posteriorly by the anterior border of the latissimus dorsi.

Three muscles that form an integral part of this triangle all have some origin from the crest of the ilium: the external oblique, the internal oblique, and the latissimus dorsi. If the external oblique and the latissimus dorsi are in close proximity and overlap somewhat as they usually do, then there is no triangle of Petit. The internal oblique thus lies under the above two muscles, and the three muscles combine to contract jointly to an increase in intra-abdominal pressure. However, if the internal oblique arises too far laterally or is thinned out and frayed, then the intra-abdominal pressure tends to push through or around the internal oblique and protrude between the external oblique and the latissimus dorsi. This, according to Adamson, is considered the mechanical factor in the production of herniation through Petit's triangle.[1]

In congenital lumbar herniation, additional factors are considered. The defect of the abdominal wall, is considered by most embryologists to be a developmental accident or arrest which occurs about the third week of embryonal life. At the 6 mm. stage or at the third week of embryologic development the

myotomes are completely formed. At the 10 mm. stage or at the fifth week the superficial portions of the myotomes fuse to form the myotomic column, the ventral edge of which later forms the trunk musculature. Tangential splitting from the myotomic column results in the oblique muscles. Arrest or accident at this point between the third and fifth week yields the abdominal wall defect. Arey states that a whole muscle or part of a muscle may be lacking because of agenesis.[2] The possibility of frayed or thinned out muscles is thus more easily understood.

Incidence

Less than 40 cases of congenital lumbar hernia have been reported. Only three of these have been bilateral (Coley 1921, Flickinger and Masson 1946, Adamson 1958).

Case Report

This 5 lb. 14 oz. Negro female infant was born spontaneously at St. Elizabeth Hospital, Dayton, Ohio, on November 13, 1964. The mother was prima gravida. There were no remarkable findings in the pregnancy history. Gestational period was 40 weeks.

Physical examination at delivery was unremarkable. However, ten minutes after delivery a large compressible soft tissue mass was noted in the left flank (Fig. 2). Closer

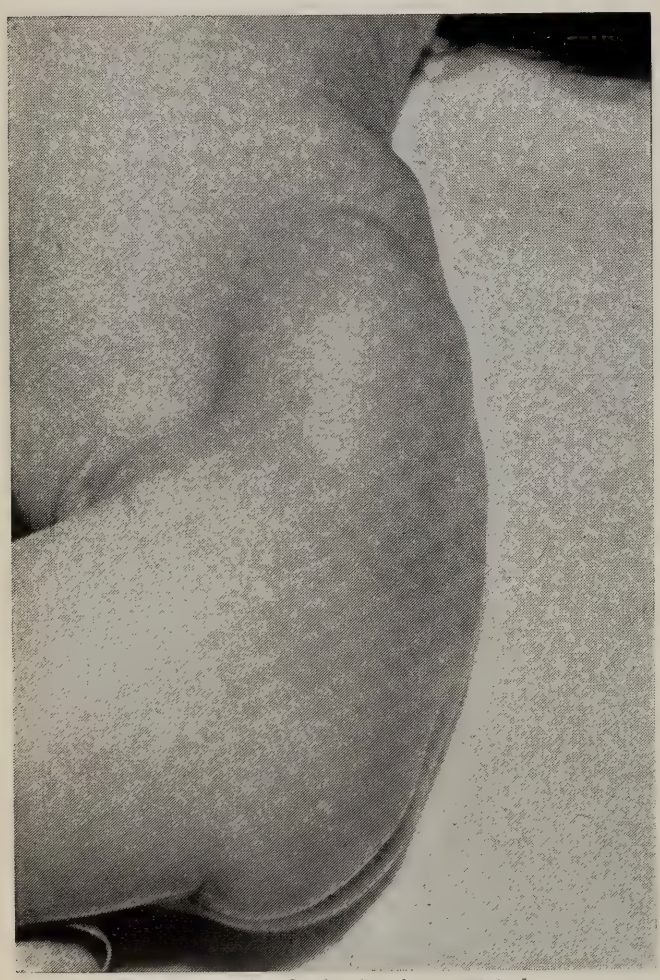


FIG. 2. *Left Flank of Infant at Birth.*

examination revealed a defect of the fascial wall of the left flank which involved not only Petit's triangle, but also Grynfeltt's triangle, the defect extending from the 12th rib down to the iliac crest. There was a smaller defect felt in the right flank just above the iliac crest in the region of Petit's triangle, but it was only a slight bulge seen mainly when the patient was crying.

Flat film of the abdomen and barium enema on the first day revealed a loop of sigmoid colon included in the left flank mass. Intravenous pyelogram on the third day was normal. X-rays revealed the right diaphragm elevated to rib 6 anteriorly and to rib 7 posteriorly.

The diagnosis of congenital lumbar hernia was made, and at 7 days of age the patient was taken to surgery. An oblique skin incision was made over the left flank mass. The hernia sac was delineated by sharp dissection. The hernia protruded through the flank wall with marked attenuation of the transversus abdominis muscle and the internal oblique muscle, with sparse slips of these muscles present stretched over the sac. Borders of the external oblique and latissimus were identified and observed to be better developed. The sac (which consisted of peritoneum and overlying thin fascial layers) was depressed and, without excising the sac, repair was carried out by imbricating external oblique to latissimus dorsi with 3-0 silk sutures. This left triangular weaknesses in the superior-most portion of Grynfeltt's triangle and the inferior-most portion of Petit's triangle. These areas were reinforced with sutures. Subcutaneous fascial layer was approximated with 4-0 silk and the skin with 5-0 silk sutures. The wound healed nicely per primum.

Follow-Up: No surgery was contemplated for the defect of the right Petit's triangle nor for the eventration of the right diaphragm since both were asymptomatic.

At eight weeks of age the infant was admitted to the hospital with right-sided atelectasis and pneumonitis. The child responded well to antibiotics and moisture per croupette. Because of the atelectasis it was felt that the eventration on the right side should be repaired electively in the immediate future as well as the right lumbar defect. The parents wished to defer the surgery, however. On subsequent visits the child has been found to be developing well. The Petit's triangle defect on the right has become smaller. The child is now eight months old and shows no evidence of herniation from the right Petit's triangle and has had no further episodes of respiratory difficulty. Therefore no further surgery is contemplated at the present time. The left flank remains stable.

Discussion

This rare type of hernia represents a mesodermal defect of the myotome or an arrest of normal development resulting in attenuation and absence of a portion of the deeper flank muscles. The same mesodermal arrest of development may occur with the diaphragmatic muscle development, which may result in a hernia through the foramen of Bochdalek or an eventration as was seen in this case. This differs in origin from the acquired lumbar hernias seen in the adult age group.

Treatment

An intrinsic surgical repair of the defect or imbrication should be carried out utilizing the patient's own tissues if at all possible. Rarely, if ever, is exogenous material such as Marlex mesh necessary for the repair either of congenital lumbar hernia or diaphragmatic hernias. Primary repair is more easily accomplished in infants because of the marked elasticity of the tissues and because of continued muscle and fascial development. Other methods of repair found in the literature which have worked satisfactorily are a free graft of fascia lata or a repair utilizing a flap developed from the tensor fascia lata.

Summary

1. Congenital lumbar hernia is extremely rare, with less than 40 cases recorded, and this the fourth

reported bilateral congenital lumbar herniation.

2. Differences between the congenital lumbar hernia and acquired lumbar hernia with anatomic landmarks are discussed, stressing the fact that congenital lumbar hernia is an arrest of normal muscular development.

3. Treatment is an intrinsic surgical repair without delay, aimed at reducing the bulge and imbricating surrounding musculofascial layers as necessary over the defect to bring about a solid flank wall.

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THOUGHTS ON TEACHING MEDICINE. — The students I enjoy teaching most are those who after two or three years of university education are confronted for the first time by a real patient. They are fascinated, if given the chance, by the infinite variety of human personality and experience which is presented to them.

The first staggering fact about medical education is that after two and a half years of being taught on the assumption that everyone is the same, the student has to find out for himself that everyone is different, which is really what his experience has taught him since infancy. And the second staggering fact about medical education is that after being taught for two and a half years not to trust any evidence except that based on the measurements of physical science, the student has to find out for himself that all important decisions are in reality made, almost at unconscious level, by that most perfect and complex of computers the human brain, about which he has as yet learnt almost nothing, and will probably go on learning nothing to the end of his course — this computer which can take in and analyze an incredible number of data in an extremely short time. And the data are mostly not of the hard crude type with which that simple fellow the scientist has to deal, but are of a much more subtle, human, and interesting character, each tinted in its own colors of personality and emotion.

All this the student has to discover for himself while his teachers strangely pretend to believe that the secrets of medicine are revealed only to those whose biochemical background is beyond reproach. — Sir Robert Platt, BT., M. D., M. Sc., F. R. C. P., F. C. G. P., *British Medical Journal*, 2:551-552, September 4, 1965.

PRESCRIPTION MEDICINES cannot be bought over the counter and can reach the public only through experts, members of the medical profession. There is no parallel to this situation with any other commodity, in which the industry supplies, the doctor prescribes, and the patient consumes, with the doctor figuratively watching over the patient's shoulder to evaluate the effect and the safety of the product. . . . The entire billion prescriptions filled in 1966 will cost the American people about one-sixth the estimated cost of landing the first American on the moon. — J. Mark Hiebert, M. D., Pharmacy Colloquium, University of Kansas Centennial, Lawrence, Kansas, April 13, 1966.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

PRESENTATION OF CASE

A WHITE woman, aged 68 years, entered University Hospital in 1964 with complaints of nausea, vomiting, and abdominal swelling. The patient stated that she had her last bowel movement approximately four weeks prior to admission. In the interim she had taken only liquids and had noted progressively increasing abdominal distention with nausea and vomiting for the week before admission. She also complained of pain in her right shoulder. She denied bloody or tarry stools or intermittent diarrhea.

Although the patient was a very poor historian, it could be determined that she had been taking no medications and that she had had tuberculosis in 1918. Between 1937 and 1950 she made repeated outpatient visits with complaints of alternating right upper quadrant pain, nausea, or diarrhea. A barium enema in 1942 was reported to show "no evidence of organic pathology of the colon." A cholecystogram was normal, but an upper gastrointestinal series was interpreted as showing "duodenal ulcer with gastric atonia" and the Sippy regime was started. When the latter two examinations were repeated in 1949, they were reported as normal. In 1949, the patient entered University Hospital with symptoms of tremor, frequent stools, 13 lb. weight loss, and irregular tachycardia. The basal metabolic rate was plus 29 per cent and the radioactive iodine uptake was 56 per cent. After treatment with 4 mc. of I^{131} the patient was discharged. At the Clinic six months later, the patient had symptoms and laboratory data consistent with hypothyroidism and treatment was started on thyroid. She refused to take her medication and subsequently became lost to follow-up.

Physical Examination

The patient was thin and appeared both chronically and acutely ill. Her temperature was 98.6°F., pulse rate 88/min., respiratory rate 24/min., and blood pressure 152/90 mm. Hg. The skin was dry and scaly and the eyes were sunken. The mouth was dry, and the neck veins were flat. The lungs were clear. The cardiac rhythm was regular and there were no murmurs. The abdomen was markedly distended and tympanitic. No liver dullness could be elicited nor was there a fluid wave. The abdomen was generally tender but not rigid. No rebound tenderness was noted. The bowel sounds were hypoactive with occasional rushes. The rectal examination revealed brown stool but no mass lesion could be palpated. There was no dependent edema; the peripheral pulses were present but weak.

Submitted March 22, 1966.

Presented by

- **William G. Pace III, M. D., Columbus, and**
- **Jacob W. Old, M. D., Columbus;**

Edited by Dr. Old.

Laboratory Data

The hemoglobin was 12.3 Gm., the hematocrit 38.5 per cent; the white blood cell count 7,528 per cu. mm. with 70 per cent total neutrophils. Platelets appeared adequate. The urine had a specific gravity of 1.026 and 10 to 15 white blood cells per high power field; sugar and albumin were negative. The blood urea nitrogen was 88 mg., the creatinine 1.3 mg. per 100 ml. The serum sodium was 139 mEq., the potassium 3.1 mEq., the chlorides 94 mEq., and the CO_2 combining power 29 mEq. per liter.

X-ray examination of the abdomen showed a grossly distended large bowel with free intraperitoneal air and two fecal masses in the left lower quadrant. The colon filled only to the midsigmoid region on barium enema.

The electrocardiogram showed low voltage but was otherwise within normal limits.

Hospital Course

The sigmoidoscope was admitted only to the level of 15 cm. and no tube could be passed through it. The patient was prepared for surgery with intravenous fluids, antibiotics, and whole blood. Never-

theless she remained hypotensive and tachycardia persisted. The urinary output was less than 100 ml. At laparotomy, 12 hours after admission, the peritoneum was found grossly contaminated and a temporizing procedure was performed. During surgery the patient required 4 units of blood, 400 mg. Solu-Cortef,® and a Neo-Synephrine® rinse. Soon after arrival in the recovery room the systolic blood pressure was above 100 mm. Hg, and the heart rate was normal.

Initially the urine output averaged 40 to 50 ml. per hour, the specific gravity 1.015-1.020. During the next 14 hours her blood pressure slowly fell to 50 systolic and the pulse rate rose to 100-120. The urinary output fell to zero yet the central venous pressure ranged from 8 to 12 cm. of water. Venipuncture sites failed to clot and bleeding was noted in the oral cavity. The patient was thought to be hypothyroid and to have an underlying blood dyscrasia as well as hypofibrinogenemia. Laboratory studies showed a hematocrit of 48 per cent, hemoglobin 15.4 Gm., white blood cells 6,480 with 61 per cent neutrophils and 34 per cent juvenile myelocytes; platelets 840,000; fibrinogen 0.141 Gm. per 100 ml.; prothrombin time above 21 minutes (less than 10 per cent). The blood urea nitrogen was 26 mg. and creatinine 1.3 mg. The amylase was 52 units. Despite controlled respiration, vitamin K, fibrinogen, Amicar,® fresh whole blood, steroids, antibiotic therapy, vigorous fluid replacement, mannitol and intravenous calcium, the patient died at 10:23 p. m. on the second hospital day.

CLINICAL DISCUSSION

DR. PACE: We have here today the case of a 68 year old woman who had been without bowel movements for four weeks. We do not know exactly how long she was seriously ill prior to her admission here, but we note that she had acute symptoms with pain in her right shoulder and nausea and vomiting about one week prior to her admission.

The past history has a couple of interesting points in it. On her upper G. I. in 1942 she had a duodenal ulcer and was started on a Sippy diet. Then about seven years later she was hospitalized when she had clinical hyperthyroidism with a BMR of plus 29. She was given 4 millicuries of I^{131}, which I assume was an adequate dose since it seems to have resulted in clinical hypothyroidism after an interval of six months.

She was lost after that visit and came back 16 years later. Her vital signs were surprisingly normal but her skin was dry and scaly. I am surprised that she was as thin as described if she was markedly hypothyroid. Her adbomen was tender but not rigid and was without rebound tenderness, which, taken with her symptoms and x-ray findings, would certainly be most consistent with perforation of a viscus without highly irritating substance in it. Such a perforation is almost certainly not gastric since, even though she is old and hypothyroid, we would expect to find some rigidity or rebound tenderness if her old ulcer had been activated. Thus I assume she perforated her colon and put relatively nonirritating stool into her peritoneal cavity, and the free air was enough to give her shoulder pain. The bowel sounds were hypoactive as I would assume they should be.

On rectal examination there was no palpable mass and brown stool was noted. If she really had had no bowel movement for four weeks I would think the stool should be pretty dry and we ought to have some note of it. Since she was a poor historian maybe this wasn't a four-week history. If she had been without bowel movement for four weeks the stool would have been like bricks in her rectum. I am trying to establish how acute this process was, because I suspect she must not have been constipated for four weeks.

DR. WILLIAMS: The stool was guaiac-negative.

DR. PACE: All right then, this was a relatively acute process, so let's question the original history of four weeks without a bowel movement.

The urine specific gravity was 1.026, which is pretty good, and her creatinine was normal, so the elevated BUN indicates an acute process — probably acute dehydration. The rest of the electrolytes except for lowered potassium aren't too far out of line; they are consistent with the moderate amount of vomiting that she had before she came in.

May we now have a review of the radiological findings?

Radiologist's Discussion

DR. DUNBAR: First is the chest film and the lung fields are clear with no evidence of cardiac failure. There is a little bit of pleural fluid and a little atelectasis at the right base, but the striking thing is the huge pneumoperitoneum beneath the diaphragms. The liver and the spleen are visible because of the surrounding air, and a nice bowel wall sign can be seen due to the air within the bowel and the pneumoperitoneum outside. The abdomen shows, in addition to the huge pneumoperitoneum, a greatly dilated colon with a large amount of fecal material in the right side. Barium enema was then done and an essentially complete obstruction in the midsigmoid or low sigmoid is identified. Now this comes down to a rather sharp point which is sometimes described as a bird's "beak." This means to us that this is probably a sigmoid volvulus. It is not completely typical because we would like to see the actual folds being twisted into the point of volvulus in spiral fashion. I certainly don't see a tumor mass here. My opinion would be that this is probably a sigmoid volvulus with perforation.

DR. PACE: Isn't this a bigger colon than you would expect to find in a volvulus?

DR. DUNBAR: That's the problem. I don't see the twisted sigmoid. This is described as a coffee-bean shadow; that is, one loop coming up, another

loop coming down with a twisted point, with the bowel wall in between making the slit in the coffee bean. Since I don't actually see the volvulus, I would say that a chronic obstructing carcinoma would also have to be considered.

DR. PACE: Is this colon larger in caliber than you would expect in acute obstruction?

DR. DUNBAR: Yes. It is quite large and I think it has been there for some period of time.

DR. PACE: How often do you see a colon this large with a hypothyroid patient who is just chronically constipated? This would put her in a category of being almost like institutionalized patients.

DR. DUNBAR: We do certainly see colons like this in mental hospitals and homes for the aged. They are possibly most prevalent in schizophrenics. I have never seen one of these large colons in such patients perforate without a point of obstruction.

DR. PACE: If they perforate, they will perforate in the cecum.

DR. DUNBAR: Sure.

DR. PACE: We are thus faced with a woman with too much free peritoneal air to have resulted from a perforation of a gastric lesion. She seems obviously to have a colon obstruction and the only question would be whether the perforation is in the cecum — and I would agree that it is a pretty big cecum — or whether it is in a volvulus which has decompressed itself by perforation and allowed these fecal balls to escape into the peritoneal cavity.

I suppose this CPC presents two problems: one is why she died, and the other is what she had to bring her to surgery. One explanation would be megacolon associated with hypothyroidism with a tendency to volvulus; this I am going to have to put first on the list. Carcinoma is certainly a possibility and I don't know any way of ruling it out other than by the unusual x-ray picture.

So, having made our surgical diagnosis of intestinal perforation, we plan to correct this with a definitive surgical procedure and try to get our patient into shape, but apparently we didn't get her quite enough into shape, because she required 4 units of blood, 400 mg. of Solu-Cortef, Neo-Synephrine, and a few other heroic measures during the procedure, which was a "temporizing" procedure — I don't quite know what that means. After arrival in the recovery room, she fell into shock. Initially postoperatively she put out 40 to 50 cc. of urine per hour with a pretty good specific gravity, but over the next 14 hours she went on a progressively downhill course starting with her drop in blood pressure, some rise in the pulse rate, and urinary output falling to zero. This, I am sure, is septic shock due to Gram-negative septicemia with subsequent fibrinolysis. I think this may explain the low prothrombin time.

The patient had a fibrinogen level of 0.141 with a normal of 0.235 to 0.339 and a prothrombin time which was less than 10 per cent. A decrease in prothrombin time associated with fibrinolysis without decrease in fibrinogen is a downhill spiral in most individuals. Sooner or later the fibrinogen falls because fibrinogen is being converted to fibrin as fast as possible with the fibrinolysis taking away all the fibrin. Fibrinogen will be exhausted before the plasmin or fibrinolysin is exhausted. The patient was given Amicar which specifically inhibits the plasminogen to plasmin conversion, and inhibits to some extent the effect of fibrinolysin directly. Unfortunately this whole course of events took only 14 hours, which is probably not sufficient time to have inhibited her fibrinolysin before the fibrinolysin inhibited her. In spite of mannitol and intravenous calcium the patient died in septic shock about 14 hours postoperatively.

So we have a woman who was elderly and who came in with four weeks of constipation — probably had more nearly 14 years of constipation perhaps associated with her hypothyroidism which was the iatrogenic result of our vigorous attempts to cure her hyperthyroidism — and her acute course probably started just a day or so prior to admission when she obviously perforated her colon and had shoulder pain. She perforated her colon, massively soiled her peritoneal cavity, had overwhelming peritonitis, barely tolerated her surgical procedure, which I guess was an exteriorization of the area involved, and then died in the recovery room 14 hours later from overwhelming septicemia.

CLINICAL DIAGNOSIS

1. Hypothyroidism.
2. Hypothyroid megacolon with fecal impaction.
3. Perforation of colon probably due to obstruction.
4. Peritonitis.
5. Septicemia with fibrinolysis.

PATHOLOGIC DIAGNOSIS

1. Fibrosis of thyroid with anatomic changes consistent with hypothyroidism.
2. Hypothyroid megacolon with massive fecal impaction.
3. Multiple idiopathic perforations of sigmoid, ascending and transverse colon.
4. Septicemia.
5. Bleeding diathesis consistent with septicemic fibrinolysis.

DISCUSSION OF PATHOLOGY

DR. OLD: I can't tell you whether the patient had a volvulus or not. The only way we can tell anything about this is from the operative notes. Was there actually a volvulus or not?

DR. WILLIAMS: No volvulus was found, Dr. Old. Dr. Westerheide in his operative note mentions two perforations — one of the transverse colon and another one approximately 1.5 cm. in size in

the sigmoid colon with a huge fecal ball presenting through this necrotic area.

Dr. Old: The first gross picture shows the temporizing procedure, which was an exteriorization of two loops of bowel — one in the epigastrium and one in the lower right quadrant. You will notice that the bowel has some degree of viability but there are focal areas of bluish-gray change which represent necrotic areas. The colon was distended with firm feces from the sigmoid area across the transverse colon and into the ascending colon. Our second gross photograph shows a large tear. Our next slide shows the cecal area dilated with fecal material. You will notice that the bowel is beginning to get apoplectic and I believe that surgeons do not like to see bowel this color.

Dr. Williams: And you are right.

Dr. Old: So, this woman was getting a kind of ischemic infarction, but we have no good mechanical reason why she should have perforated. She not only had a perforation in the sigmoid area but she had one in the transverse colonic area which was exteriorized. Both of these were described as about 6 cm. long, and several other perforations a centimeter or so in size were described in the descending colon. So we assume that something intrinsic happened to this woman's bowel to allow this. A search was made of the arteries and veins and no essential abnormality was found. So we don't have vascular thrombi to contend with, and all I can do is to presume that this woman simply got so full of fecal matter and the bowel wall became so distended that adequate blood supply wouldn't flow through. Eventually those areas with the least blood supply simply perforated.

The next photograph shows the abdominal contents. There is some fibrin deposition on the surface of the small bowel but no great amount of fibrinous adhesions. There was some ascites within the abdominal cavity. Our last photograph shows the unusual degree of hemorrhage which was present in some of the soft tissues. In other words, this patient had a rather diffuse bleeding problem as well. Now if you will turn on the lights we will go over what this case might possibly be.

The pathological protocol describes the body as well-developed and well-nourished rather than thin as stated in the clinical protocol. Everybody has a different criterion for where fat and thin commence. The skin was described as dry, scaly and coarse, the face slightly puffy. This of course goes along with some degree of hypothyroidism, and I think this is probably the basic mechanism of this patient's illness and death. She had no functional thyroid whatsoever left at autopsy, and according to the clinical record she didn't take her thyroid properly after her radioiodine treatment, but we don't know what medications she had been on during these 14 years. One would presume that she was taking thyroid hormone intermittently or at least in enough dosage to keep her out of marked hypothyroidism if she got along for 14 years with a thyroid as fibrotic as hers.

Hypothyroidism has many manifestations. On the cardiovascular side, there is low stroke volume and relative bradycardia, and this woman, who had some degree of peritonitis and showed signs of it on admission, didn't have a very high pulse rate. Cardiac failure may occur, but I don't know whether this was the case in this particular instance. Cardiac changes with myxedema are rather nonspecific — the so-called flabby heart, which was present. At autopsy the heart has no rigidity and no essential mass to it, but this may also occur with many debilitating illnesses.

Another feature in this case was very marked coronary arteriosclerosis, which is also seen with hypothyroidism. These patients are said to be somewhat like diabetics in that hypothyroidism predisposes them to excessive arteriosclerosis and the coronary arteries are often severely involved. Some clinicians recommend the slow treatment of hypothyroidism to avoid precipitating angina pectoris, which may occur if the patient becomes euthyroid too fast.

The hypothyroid patient manifests a number of symptoms related to the gastrointestinal tract: impaired secretions, occasional examples of malabsorption due to myxedema, and of course atonia is the main consideration with constipation which may even go on to megacolon. This patient's history may have been more accurate than it sounded in that the fecal contents were too voluminous to have accumulated in a short period of time and I presume that she may not have had a bowel movement for at least a couple of weeks anyway.

As for bleeding disorders, there is little in the literature related to hypothyroidism, so the mechanisms that Dr. Pace mentioned are probably as good as any, although peritonitis was not marked. There have been bleeding problems described with hypothyroidism, but it's not too clear what they are. It has been suggested that hypothyroidism may lead to a deficiency of so-called stable factors of the clotting mechanism. Possibly the vitamin K deficiency was due to a poor diet.

The adrenal glands have sometimes been a factor, and steroids apparently may sometimes be required in control of myxedema patients.

Finally, these patients with myxedema can apparently undergo comatose changes and mental aberrations just on the basis of hypothyroidism itself. Apparently the thyroid hormone is necessary for metabolism within the brain and the brain cells gradually decrease their function like all other cells with the deficiency. This leads to lowered cerebral metabolism and then to lowered reflexes, and finally to lowered breathing with an accumulation of CO_2 in the process, and these patients are described as brittle to any type of shock. In other words, if she

were basically a hypothyroid patient at the time of surgery, she would be very susceptible and very difficult to control as a postsurgical or even a surgical patient, which I think is borne out by the history.

The microscopic sections were not very helpful in this case. The thyroid was pure scar and is the main positive finding to account for hypothyroidism. The bowel was remarkable mainly for venous congestion and edema, which support my postulate of impaired circulation.

I cannot be absolutely certain of the cause of death, but I would say that in all probability it was related to the remote thyroidectomy by 4 millicuries of iodine. She probably let herself get myxedematous and got into various chronic problems including the colon, and I believe one can get enough of a fecal impaction to cause rupture just on the basis of the impaction itself. This one was really extensive, running from the sigmoid colon all the way around almost to the cecum, and the perforations were down in the older parts of the impaction. We will occasionally observe at autopsy a type of ulceration known as stercoraceous ulcer in fecal impactions, which apparently is due simply to pressure of the fecal mass against the mucosal wall to the point where it cuts off circulation. Capillary circulation can be cut off so that ulcerations may occur, and I would suggest that this is probably the mechanism by which these lesions finally perforated.

DR. PACE: I just wondered whether Dr. Macpherson had any comment about hypothyroidism and the bleeding and the fibrinolysis that she subsequently presented with.

DR. MACPHERSON: I don't know of any relationship between those two. If we discuss the possible mechanisms of the fibrinolysis, rapid onset of Gram-negative shock, or endotoxic shock, in a woman who is physically unhealthy would be an important consideration in addition to surgery and the anesthesia, which can in themselves do it.

DR. MARABLE: Do you agree with the shotgun load of therapy that was given here of Amicar, fresh blood, fibrinogen, steroids, and antibiotics?

DR. MACPHERSON: Well, I don't know how many of them were necessary, but I can't say that any of them specifically would not be indicated.

MORE THAN ONE BILLION PRESCRIPTIONS will be filled in the pharmacies of America this year, of which almost 95 per cent will be produced in their entirety by pharmaceutical manufacturers, according to Dr. J. Mark Hiebert, board chairman of Sterling Drug Inc.

"This huge number of prescriptions," he said, "symbolizes the responsibility of the manufacturer in his task of producing efficacious medicines of high quality and safety, and this is uppermost in the manufacturer's mind." The fundamental responsibility of drug manufacturers consists in the manufacture of medicines of "quality, efficacy and safety." Dr. Hiebert listed other major obligations as:

- Create through research more and more life-saving and health-preserving medicines.
- Bring to the attention of physicians all new developments that may favorably affect the health of their patients.
- Alert physicians to undesirable and unanticipated side effects, contraindications, new indications when permitted to do so by law, dosages.
- Notify the medical profession immediately if product error occurs, and, if safety is at stake, withdraw the product at once.
- Adapt our policies and practices to higher standards made possible by science and technology, and to regulation by government.

ATTENTION PROGRAM CHAIRMEN: We are most anxious to receive for consideration manuscripts, abstracts, or news items based upon lectures, symposia, etc., presented to Ohio physicians or those presented by Ohio physicians to other groups. — THE EDITOR.

Maternal Mortality Report For Ohio-1963*

By the OSMA COMMITTEE ON MATERNAL HEALTH

THE Committee on Maternal Health presents its NINTH Annual Report in compliance with a House of Delegates directive adopted April 23, 1953 which created the Committee, and follow-up action taken by the OSMA Council, January 16, 1954.[1]

Five Sections comprise this report, the first consisting of a resumé of activities of your Committee since its last report to The Council on September 19, 1965.[2] The second portion describes various projects developed and pursued by the Committee in fulfilling its prescribed functions.

Section Three presents a statistical summary of The Ohio Maternal Mortality Study for 1963* covering 88 counties in the state, while the following portion analyzes the data. As the reader will note, the material includes figures for patients who died outside of hospitals as well as for those who died during hospitalization. In the final part, recommendations are advanced by the Committee, based upon its experiences in the study and allied facets.

Activities

The Committee on Maternal Health consists of the same 20 members mentioned in the last annual report; the chairman and one member have been on the Committee since its incipience. Previously mentioned, through its members the Committee not only represents the 11 Councilor Districts of Ohio, but also reflects an excellent cross section of general practice, obstetrics, gynecology, cardiology, pathology, and anesthesiology.

Quarterly the Committee has met. Perhaps the most effective meeting of the group is the annual two-day conference held at Granville in the famous Inn. Besides conducting many items of important business, during this meeting January 22 and 23, 1966, the Committee studied, reviewed and classified 72 maternal death cases. In the customary manner, "Guiding Principles for Obstetric Care"[3] was used as a minimum standard to assess avoidability in each case.

In this column titled "Maternal Health in Ohio" the Committee continues to publish an article each quarter year. Besides the annual report to The Council, its subjects include various primary causes of maternal death gleaned from cases in The Ohio Study. Frequently brief case reports are published to provide further educational media, through concise pertinent comments.

During a presentation of the Committee's report to The Council at a meeting in 1965, several members displayed great interest in The Ohio Study. One presented queries concerning "Child Outcome" in the death of various mothers. Another asked about the significance of "Prenatal Care" in connection with maternal mortality. After a lengthy survey of material in The Ohio Study, in answer to these questions an article was published on the subject, appearing in this column in March, 1966.[4]

The Committee supports well established county maternal death studies operated in Cleveland, Columbus, Cincinnati, Dayton and Toledo. In addition, the Committee was delighted to assist in the organization of a newly augmented maternal mortality study, to operate continuously on a county-wide basis as a cooperative effort — the Akron Obstetrical and Gynecological Society and the Summit County Medical Society. This study was duly authorized January 1, 1966; physicians of the community are to be complimented upon this accomplishment.

Projects

The data processing system coding information from questionnaire forms onto IBM cards continues. To date, data from 1084 maternal cases have been transcribed to the cards for the first nine years of The Ohio Study, 1955 to 1963, inclusive. As the files of completed cases grow, more cases (old and new) are added, to provide a wealth of material for information and education.

As this article goes to press, a subcommittee is preparing an exhibit for the Committee, to be displayed at the annual OSMA meeting in Cleveland, May 24-28, 1966. The title: "Maternal Deaths Due to Anesthesia." Efforts were coordinated with The Ohio Society of Anesthesiologists, Inc.

In a collateral fashion, the Committee is assisting The Ohio Society of Anesthesiologists, as the latter plans and pursues a new program devised to ascertain

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the State. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

the practices and needs for personnel and facilities connected with OB anesthesia in Ohio hospitals; thereafter the program will be directed toward measures recommended to meet these needs.

At the request of The Council, the Committee studied certain proposed changes to be made on the official certificates of live birth, death and stillbirth (fetal death). Specific recommendations were made by the Committee; however subsequently it was learned that the U. S. Department of Health, Education, and Welfare (HEW) had delayed revision of these forms for one year.

During the annual meeting at Granville, a new project was developed following prolonged discussion and final deliberation. This was tagged the "Medically Avoidable Maternal Death" program of education, aimed to further educate physicians in their early responsibility to advise and guide the (cardiac, diabetic) patient concerning future pregnancies, etc. Future reports will be forthcoming.

Under direction of The Council, the Committee on Maternal Health thoroughly investigated planning and implementation of a national project entitled "National Foundation Prenatal Care Project" (NFPNCP) sponsored by "March of Dimes." Available material was studied and discussed. Recommendations were made by the Committee to The Council and approved (see *The Ohio State Medical Journal,* 61:1004-1005, November, 1965). The NFPNCP carried a fetching slogan, "Be good to your baby before it is born. Seek Prenatal Care. For further information contact your local Chapter, National Foundation, March of Dimes." Subsequently a conference was held with a district representative of the National Foundation; officials of OSMA, and a member of the Committee were present. It was pointed out by the latter that the medical profession founded prenatal care in the United States. In conclusion it was suggested that the Foundation, in consultation with the AMA, revise the NFPNCP to establish it on a scientific basis that the medical profession would be able to support.

Utilization of Maternity Beds

The Committee on Maternal Health and the President of OSMA were introduced to another new project, on an advisory basis. On March 16, 1966 by invitation, with the Ohio Director of Health, they attended an initial conference with the Governor's Ohio Hospitalization Benefits Committee. Purpose of the conference was "To examine the possible alternative use of existing maternity units in (Ohio) general hospitals for 'appropriate' gynecological cases in order to have more effective utilization of existing facilities." It was pointed out that there has been a progressive annual decline in Ohio live births since 1957 (Fig. 1).

As this article is being processed for publication, additional conferences are being scheduled. The project "GYN Patients on OB Floors, Draft No. 7" developed after tireless study by the Committee, is being surveyed by the Director of Health and the Governor's committee. By the time this article appears in print it is anticipated that the "knotty problem" will be well on its way to a favorable solution.

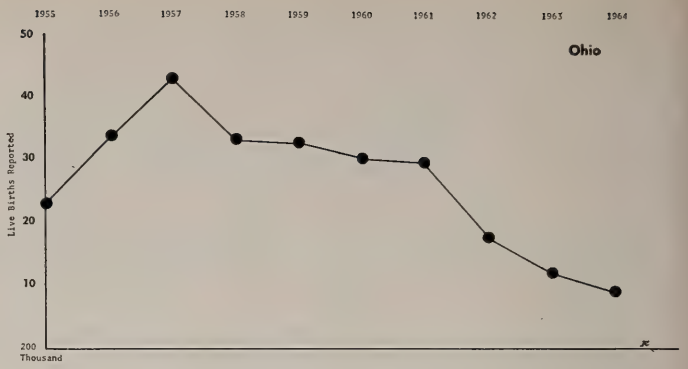


FIG. 1. *Number of Ohio Live Births per year, 10 years, 1955-1964.*

Statistics for the year 1963 from The Ohio Study are published below. They are presented in a uniform manner to facilitate comparison with similar reports issued in the past and with those to appear in the future. Terminology and nomenclature used throughout the study were adopted in 1954, after careful deliberation. They follow closely those prescribed in the International Classification, for purposes of uniformity.

Ohio Maternal Mortality Study
Statistics for 1963

Total Live Births in Ohio, 1963		212,583
(Total Cases in files, 9 years, 1955-1963....1084)		
Total Cases Studied (1963)		96
Cases not studied due to lack of information		4
Undetermined		2
Maternal Deaths (Classified)		64
Non-white	18	
White	46	
Age:		
Teens	8	
20's	21	
30's	31	
40's	4	
Parity:		
Primigravidae	17	
Multiparae	42	
Unknown	5	
Place of Death:		
Hospital	57	
Home	6	
Other	1	
Type of Delivery:		
Not Recorded	0	
Operative	33	
Nonoperative (spontaneous)	18	
Not delivered	13	
Route of Delivery:		
Not recorded	0	
Vaginal	38	
Cesarean	12	
(antemortem)	11	
*(postmortem)	1	
Laparotomy (ectopic preg.)	1	
*Not delivered	13	
Case Classification: (when death occurred)		
Not known	1	
Group I (fr. concept. to 20th wk.)	4	
Group II (fr. 20th wk. to 28th wk.)	2	
Group III (fr. 28th wk. through term)	7	
Group IV (postabortal, postpartum)	50	
Autopsies	50	
(includes 15 coroners' cases)		
Prenatal Care: (apparent from data sheets)		
None	8	
Unknown or not reported	8	
Adequate	37	
Inadequate	5	
Excluded (ecotopic preg. and abortion)	6	
Classification of Preventability:		
Nonpreventable	21	
Preventable (avoidable factor)	43	
Patient responsibility (P_1)	15	

Personnel responsibility (P_2)	19	
Both P_1 and P_2	8	
P_3	1	

Classification of Primary Causes of Death:

Hemorrhage		25
Abortion, without sepsis	2	
Abruptio	0	
Afibrinogenemia	5	
Abruptio	1	
Am. fl. embolus	2	
Dead fetus	2	
Ruptured uterus	0	
Atony, uterine, postpartum	1	
Ectopic pregnancy (without sepsis)	5	
Laceration, extrauterine	1	
Placenta Praevia	1	
Retained Placenta	0	
Ruptured uterus (no afibrin.)	8	
Other	2	
Infection		14
Abortion, alleged "criminal"	5	
Abortion, septic, spontaneous	4	
Up. Resp. Inf.	1	
Peritonitis	0	
Septicemia (puerperal sepsis)	0	
Septicemia (other)	3	
Other	1	
Toxemia		4
Acute yellow atrophy	2	
Hypertension, chronic (incl. Hypertension with cerebrovascular hem.)	0	
Eclampsia	2	
Preeclampsia	0	
Puerperal Toxemia, not specified	0	
Other		21
Amniotic fl. emb. (no hemorrhage)	4	
Anesthesia	5	
(general)	2	
(regional)	3	
Cardiac disease	4	
Cerebrovascular hemorrhage (no. tox.)	1	
Intestinal Obstruction	1	
Pulmonary embolus	4	
Renal disease, chronic, unspecified	0	
Other	2	

In Ohio, there were 212,583 live births reported during 1963. From this maternal mortality study, the Committee classified 64 *maternal* deaths for the year. The maternal mortality rate was 0.30 per 1000 live births, or 3.01 per 10,000 live births for 1963.

Discussion

Once more, in comparison, these statistics for 1963 are even more significant since there were 4,882 fewer live births reported in Ohio during 1963 than in 1962 (see Fig. 1). The progressive, gradual, annual decline in live births since 1957 has been noted above. In addition, approximately 3,000 still births *per year* reported in Ohio for the same period have neither varied nor diminished materially.

Following the usual custom, the Committee reviewed every *maternal case* carefully, studying all available facts and data on an anonymous basis. Using "Guiding Principles for Obstetric Care"[3] as a standard for "Ideal Care," each case was classified; patients receiving less than ideal care were voted *preventable* maternal deaths. Final decisions reached by the Committee were justifiably correct. With the usual observations, members realized that a number of cases *escaped* inclusion in the 1963 study, due to various reasons of omission of information on the official certificate of death.

Out of the 96 cases studied for 1963, 64 (66.6 per cent) were voted *maternal deaths,* while 26 were voted *nonmaternal deaths* (no connection with pregnancy or the puerperium). Two cases had the cause of death *undetermined* after complete investigation by autopsy.

The majority of deaths fell in age groups 30 to 39 years. Multiparae again led the parity group; 57 patients died in hospitals while six died at home. One patient was "D.O.A." at the emergency room.

Among the 64 maternal deaths, 51 patients delivered; 33 were delivered by *operative* procedure while only 18 delivered *spontaneously.* The remaining 13 died undelivered; of these only one had had a postmortem cesarean operation performed. Thirty-eight patients, (74.4 per cent) of those delivered, were delivered by the vaginal route; there were 12 antemortem cesarean sections and one patient had a laparotomy for ectopic pregnancy.

Again, the overwhelming number of patients (50 of the 63 patients) died in the postpartum or postabortal state. In one case the state was not known.

Fifty autopsies were performed on the 64 patients (78.1 per cent) including 15 coroners' autopsies. Based upon available data, the Committee voted 43 cases (67.3 per cent) *preventable* maternal deaths.[3]

A study of prenatal care statistics proved interesting. Of 50 patients in the eligible group (excluding unknown, ectopic pregnancy and abortion), 37 (or 74 per cent) received *adequate* prenatal care; three received care from a clinic while 34 received care from a physician. Five patients received inadequate prenatal care and eight received none at all.

A review of the primary causes of maternal death in the 64 cases (Fig. 2) reveals many interesting features:

Again *hemorrhage* leads the list as a single primary cause of death with 25 cases (39 per cent), including

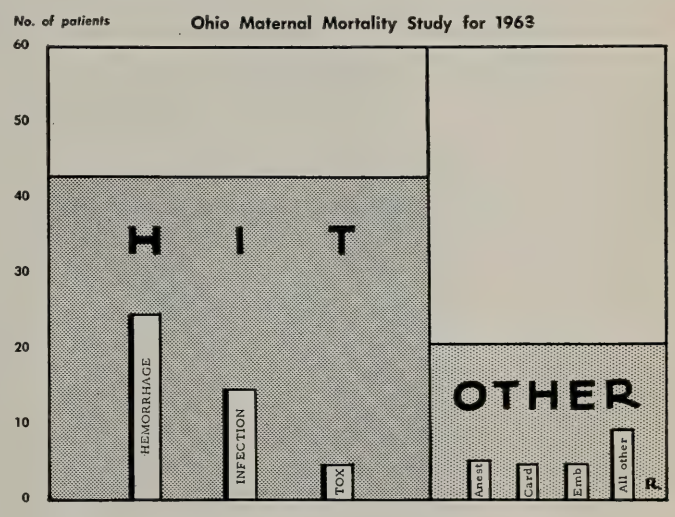


FIG. 2. *Classification of primary causes of death, 64 maternal deaths for 1963.*

eight cases of *ruptured uterus!* And once more this figure reflects the scarlet trend published in the 1962 report.[2]

Well over half the 14 cases dying of infection died following abortion. Only four patients died from toxemia, two of these developed eclampsia. Under "other causes," *anesthesia* was responsible for five of the 21 deaths. Cardiac disease and pulmonary embolus relinquish leadership with only four cases for each; an equal number of deaths (four) occurred

from amniotic fluid pulmonary embolus, proved at autopsy.

The two "other causes" in this last group bear a brief description: Case No. 913 developed abruptio placenta, hemorrhage, gastric hemorrhage, then vomited and aspirated causing death. Case No. 939, through a coroner's autopsy, died of "accidental anoxia, no other cause found."

The distribution of causes of death during 1963 is strikingly similar to those listed for 1962 (Fig. 3).

Recommendations

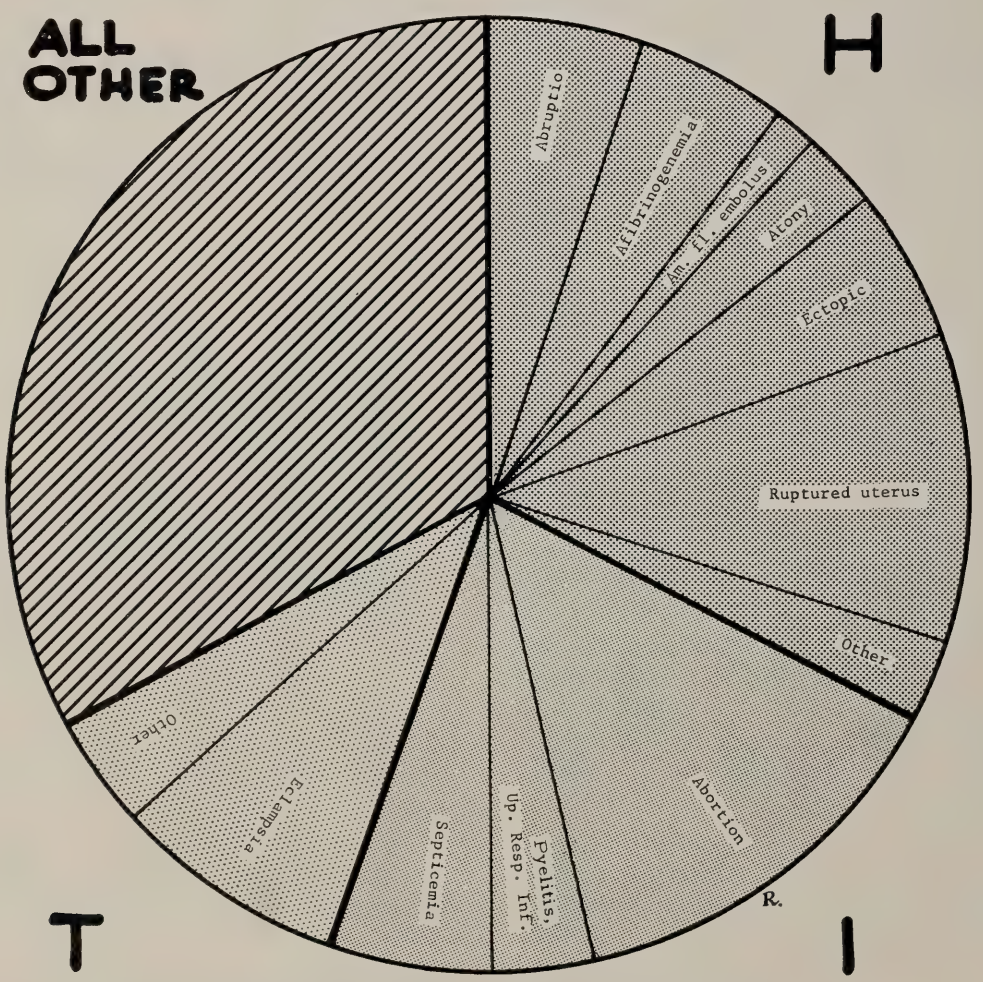
1. Again the Committee recommends that The Ohio Maternal Mortality Study with its research and educational facets, be continued to reduce further the maternal mortality and morbidity in Ohio. Trends in maternal deaths can be controlled only through constant evaluation of factors producing this mortality, followed by a program of education which is focused towards the causative factors.

2. Once again it is recommended that county medical society presidents appoint the chairmen of (local) Committees on Maternal Health for terms longer than one year. Through some adjustment in local customs, this committee chairman then would not terminate his one-year tenure just as he became familiar with the operation of his local study. A term of three years is recommended.

3. It is reiterated that county Committees on Maternal Health should establish closer liaison with local vital statistics bureaus and respective offices of the coroner. It is recommended that greater effort be exerted to discover maternal cases where the patient dies at home or elsewhere. These cases, of which a fair number now escape inclusion in the study, should be included.

4. In the past, members of The Council have supported The Ohio Maternal Mortality Study with constant devotion. It is recommended that members remind program chairmen of county medical societies that speakers from the Committee are available for local schedules, to present topics or discussions concerning "Maternal Health in Ohio." Correspondence may be addressed to the Committee on Maternal Health, OSMA Headquarters, 17 South High Street, Suite 500, Columbus, Ohio 43215.

The Chairman takes this opportunity to express sincere appreciation to members of the Committee for continued loyal support and for faithfully discharging their duties. Furthermore, the Committee gratefully



Ohio Maternal Mortality Study for 1962

FIG. 3. *Distribution of Primary Causes of Death, 66 Maternal Deaths in Ohio.*

acknowledges the assistance provided by attending physicians, representatives of various county medical societies, The Ohio Department of Health and numerous other agencies and individuals. Without their untiring cooperation, this Maternal Mortality Study could not have been compiled.

Respectfully submitted,

ANTHONY RUPPERSBERG, JR., M.D., *Chairman, Committee on Maternal Health*

Approved by The Council of the Ohio State Medical Association, April 24, 1966.

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3. Guiding Principles for Obstetric Care. *Ohio State M. J.*, 53:1328-1329, 1957 (Revised 1963).

4. Ruppersberg, Anthony, Jr.: Adequate Prenatal Care — "Be Good to Mother Before Baby is Born." *Ohio State M. J.*, 62:247-248 (March) 1966.

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2. **Correspondence.** Address all correspondence relating to publication of scientific papers to: The Editor, The Ohio State Medical Journal, 17 South High Street, Suite 500, Columbus, Ohio 43215.

3. **Manuscripts.** (a). Manuscripts should be submitted in the original on standard 8½" x 11" white typing paper.

(b). The entire text including case reports and lists of references should be typed double or triple space with margins of at least one inch on all sides.

(c). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by a concise, descriptive title. In the text, reference to them should be made by number, e. g. (Fig. 1). We shall place the figure as close as possible to this reference in the printed text.

(d). A copy of the manuscript should be retained by the Author.

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"2. Doe, J., and Roe, R. X.: How to Go About It. Ohio State M. J., 13:24-30 (Feb.) 1920."

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page, e. g.

"5. Osler, W.: Modern Medicine, ed. 3, Philadelphia, Lea & Febiger, 1927, vol. 5, p. 66."

8. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

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Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

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1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

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SEARLE

Research in the Service of Medicine

Proceedings of The Council...

Minutes of the Meeting of April 23-24; With Reports of Numerous Matters Discussed and Official Actions Taken

A REGULAR MEETING of The Council of the Ohio State Medical Association was held April 23 and 24, 1966, in the new headquarters office, 17 South High Street, Columbus. All members of The Council were present except Dr. Robert E. Howard, Cincinnati, Councilor of the First District, and Dr. George Newton Spears, Ironton, Councilor of the Ninth District. Others attending the meeting were: Dr. John H. Budd, Cleveland, chairman, Ohio Delegation to the American Medical Association; Mr. Wayne Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA field representative; Dr. Anthony Ruppersberg, Columbus, chairman, OSMA Committee on Maternal Health; Dr. Edmond K. Yantes, Wilmington, president, Mr. Charles H. Coghlan, Columbus, executive vice-president, Ohio Medical Indemnity, Inc.; Dr. William Hamelberg, Columbus, president of the Ohio Society of Anesthesiologists; Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff.

Resolution in Memoriam

The following resolution concerning the death of Dr. Fred W. Dixon, Cleveland, was submitted by Dr. Robechek, and by official action **was adopted** by The Council:

WHEREAS, Fred W. Dixon, M. D., of Cleveland, a Past President of this Association and a former member of this Council, died April 11, 1966, and

WHEREAS, this physician and surgeon established in his lifetime a distinguished record of service to his patients and to his profession, and

WHEREAS, his dedication, humility and relationships with his patients and his fellow physicians gained for him the admiration and respect of all who were privileged to know him, now therefore

BE IT RESOLVED, that The Council of the Ohio State Medical Association hereby pays tribute in memoriam to this distinguished physician, and

BE IT FURTHER RESOLVED, that deepest sympathy is extended to his widow, and

BE IT FURTHER RESOLVED, that this resolution be made an official part of the records of this Association, that a copy of it be forwarded to Mrs. Dixon, and that it be suitably printed in the official publication of this Association.

Unanimously adopted by standing tribute
April 23, 1966
Henry A. Crawford, M. D., President
Hart F. Page, Executive Secretary

Minutes Approved

Minutes of the meting of The Council held March 20, 1966, **were approved** by official action.

Membership Statistics

The following membership statistics were announced by Mr. Page: OSMA membership as of April 22, 1966, 9,524, compared to a total membership of 9,471 on April 22, 1965, and 10,042 on December 31, 1965. He reported that of 9,524 members, 8,507 were affiliated with the AMA.

Reports of Councilors

The Councilors reported on activities in their respective districts.

1966 Annual Meeting

Mr. Traphagan presented a progress report on developments concerning the Annual Meeting of the Association in Cleveland, May 24-28.

A total of 44 resolutions to be presented under the 60-day rule at the first session of the House of Delegates were distributed to The Council for information.

New Section on Plastic Surgery

In answer to a request from Clifford L. Kiehn, M. D., Cleveland, The Council **approved** the formation of a Section on Plastic Surgery for the Ohio State Medical Association. The Executive Secretary was instructed to advise Dr. Kiehn of the procedure for establishing such a section.

Letter Regarding 1965 Resolution

A letter from George H. Hoke, M. D., Lorain, Secretary of the OSMA Section on Neurological Surgery and the Ohio Neurosurgical Society, transmitting a copy of a resolution passed at the 1965 meeting of the Section on Neurological Surgery, was submitted to The Council. Such letter concerned Resolution No. 22 adopted by the 1965 House of Delegates.

The Executive Secretary was directed to inform Dr. Hoke that the procedure of acting on resolutions at a section meeting is out of order in accordance with Chapter 3, Section 5 of the Bylaws of the Ohio State Medical Association. This provision limits section activities to scientific subjects. It was further pointed out by The Council that resolutions may be properly presented by submitting them through an officially elected delegate to the Ohio State Medical Association in accordance with Chapter 4, Section 8 of the Bylaws of the Association.

June AMA Meeting

The Council voted to instruct the Ohio delegates to the American Medical Association to support the

proposed $25 increase in annual AMA membership dues, to become effective January 1, 1967 if approved.

Mr. Page reported to The Council on developments in plans for the President's Reception in honor of Dr. Charles L. Hudson, Cleveland.

On **motion** duly made, seconded and **carried,** The Council instructed the Ohio delegates to the American Medical Association to nominate Dr. John H. Budd for the office of vice-speaker of the American Medical Association and to conduct a campaign in support of Dr. Budd prior to and during the AMA meeting in Chicago, June 26-30. The Council authorized the expenses necessary to carry on the campaign and authorized the staff to proceed with its implementation.

Mr. Stichter presented a report for the information of The Council which indicated that there is nothing in the Illinois statutes or in the Articles of Incorporation of the American Medical Association requiring that a citizen from the State of Illinois be a member of the American Medical Association Board of Trustees.

Texas Resolution

A communication from the Texas State Medical Association, which included resolutions adopted by that Association's House of Delegates, April 15, 1966, on the subject of the individual responsibility of the physician, direct billing, and eliminating third party interference in the doctor-patient relationship, was distributed to members of The Council for information.

Ohio Medical Indemnity, Inc.

By official action, Council ratified a mail vote conducted April 8 on the nomination of five members of the Board of Directors of Ohio Medical Indemnity, Inc.

Dr. Tschantz reported for the OMI Liaison Committee on the annual meeting of the OMI Board of Directors held April 20, 1966.

Dr. Yantes and Mr. Coghlan reported to The Council on development of procedures for indemnifying patients of hospital-based physicians.

Mr. Coghlan reviewed meetings OMI has held with the Ohio State Radiological Society and discussed details under way in preparation for issuing an Ohio Medical Indemnity policy to indemnify patients for radiological fees.

Mr. Coghlan also discussed Blue Cross - Blue Shield advertisements which had raised objections from physicians in several areas. He indicated that the Blue Cross Plans have been notified that Ohio Medical Indemnity requests that OMI and the Blue Shield name not appear in any advertising on the subject of "Medicare."

Council voted to ask officials of Ohio Medical Indemnity, Inc. to confer with responsible members of the Ohio Society of Anesthesiologists, with the expressed hope that individual and direct billing can be extended to anesthesiology claims submitted to Blue Shield. A report on this matter was requested for the next meeting of The Council.

Name of Committee Changed

The Council approved the change in the name of the special Committee on Care of the Aging to the Committee on Government Medical Programs.

Workmen's Compensation

Developments in the usual and customary fee program under Ohio Workmen's Compensation were presented by Dr. Diefenbach and Mr. Edgar. After a lengthy discussion, The Council directed that a combined exploratory meeting on the subject be conducted, beginning with a luncheon at noon, May 18, 1966, with members of the Industrial Commission and representatives of the Ohio Manufacturers' Association, self-insurers, chairman of the OSMA Committee on Workmen's Compensation and others. In addition, The Council authorized the President of the Ohio State Medical Association to confer with the review committee of the Cincinnati Academy of Medicine regarding problems in Workmen's Compensation fee bills.

Maternal Health

Dr. Ruppersberg presented the minutes of a meeting of the committee held April 17. The minutes included a commendation to Dr. Gilbert M. Schiff, Cincinnati, for his efforts in promoting a progressive study in Rubella antibody detection. Information concerning the chairman's appearance, by invitation, before the Ohio Hospitalization Benefits Committee, February 23 and March 17, 1966, to discuss with the committee problems involving integrating clean gynecological patients on maternity floors of general hospitals, was included in the report. The minutes **were approved** as presented.

1963 Maternal Mortality Report for Ohio

The 1963 Maternal Mortality Report for Ohio was presented by Dr. Ruppersberg and received the **approval** of The Council. (The text of the report is on pages 585-589 of the June issue of *The Ohio State Medical Journal.)*

ODH Laboratory Advisory Committee

On invitation from the Director of the Ohio Department of Health, the President was authorized to designate six physicians who utilize laboratory services, two of whom will be selected by the director for appointment to the Laboratory Advisory Committee for the department.

The President was instructed to write to Director Arnold for clarification with regard to why the Ohio State Medical Association was asked to submit the names of physician users of laboratory services and why nothing was said about suggestions of names for pathologist members for the committee.

Ohio State Medical Board

Dr. Merchant reviewed the historical development and the legislative background of the Ohio State

Medical Board. He told The Council of current problems faced by the Board in dealing with "professional incompetence" and "mental incompetence" on the part of licensees. He emphasized also the need for certain immunity provisions to permit the Board to take action without jeopardy to itself and the necessity to provide protection for investigators hired by the Board. He told The Council about the need for multiple choice examinations and electronic data processing in the grading of examinations. He contrasted this system with the present essay-type examination system in Ohio.

He indicated that salaries of the executive secretary of the Board and employees must be raised and additional personnel obtained.

By official action, The Council directed that the OSMA Judicial and Professional Relations Committee meet with the Ohio State Medical Board for the purpose of developing legislation necessary for the rewriting of the Ohio Medical Practice Act.

Ohio Association of Blood Banks

A request for approval of the Ohio Association of Blood Banks was submitted along with a proposed constitution for such organization. It was the expression of The Council that it found nothing objectionable about the formation of such organization.

United Medical Laboratories, Inc.

A complaint regarding communications issued by a physician in connection with the United Medical Laboratories, Inc., was brought before The Council. It was The Council's opinion that this matter is under the jurisdiction of the Columbus Academy of Medicine, and the Executive Secretary was instructed to refer the matter to the Academy.

Vocational Rehabilitation

A communication from the Bureau of Vocational Rehabilitation, stating that Federal authorities require the bureau to have a published fee schedule, was discussed by The Council. It was the expression of The Council that it would be necessary to review a copy of such regulation before the matter could be satisfactorily considered. The Executive Secretary was instructed to request this information.

VA Hometown Program

Presented for the information of The Council was a letter from R. K. Laubhan, M. D., Chief, Outpatient Service, Veterans Administration Hospital, Cleveland, and an attached relative value fee schedule which will be used for the hometown program of the VA beginning July 1, 1966. The Council **approved** a letter written to Dr. Laubhan on April 11 by the Executive Secretary, indicating that the present policy of the Ohio State Medical Association does not permit the execution of a letter of agreement with the VA on behalf of OSMA members.

Health Survey

A communication from Arthur J. McDowell, chief, Division of Health Examination Statistics, Department of Health, Education, and Welfare, announcing that a Public Health Service health survey will be conducted in the Ashtabula-Geauga area to examine a sample of the teen-aged population during a four-week period this summer, was presented to The Council. This is the third cycle of the survey. Earlier a second cycle of children's health examinations was completed and during the first cycle ending in 1962 a three-year survey of adults was completed. The department indicated that the survey is designed to collect data primarily on the health aspects of growth and development.

Request for Contribution to School Project

A request from the Ohio Academy of Science for suggestions and funds for implementation was considered by The Council. It was indicated that the communication was submitted too late for consideration this year and it was suggested that the Academy be advised that it is necessary for such requests to be received by the Ohio State Medical Association prior to the annual budget meeting in December.

Proposed Statute for Disposition of Tissues and Organs after Death

The Council reviewed a request from the Cleveland Academy of Medicine that the Ohio State Medical Association consider legislation directed toward the Ohio General Assembly on the subject of the disposition of tissues and organs after death. The Council **approved** the idea in principle, but specified that any proposed legislative drafts be submitted to The Council for review prior to the granting of approval by the OSMA.

Letter from Mr. J. Edwin Farmer

A letter dated March 22, 1966 from Mr. J. Edwin Farmer, Columbus, was presented to The Council. Such communication involved Mr. Farmer's proposed trade association building. In reply The Council directed Mr. Farmer's attention to a letter written to him by Mr. Page on May 17, 1965, with specific attention to the final paragraph thereof.

Kellogg Grant to Hospital Association

Information was presented to The Council concerning a grant to the Ohio Hospital Association from the W. K. Kellogg Foundation, Battle Creek, Michigan, in the amount of $61,697 for a three-year program to assist "with the development and improvement of long term and extended care facilities and services."

American Nursing Home Association

The Executive Secretary was instructed to send a letter to the American Nursing Home Association, asking what programs are planned or are under way under its jurisdiction with regard to research and development in the improvement of long-term and extended care facilities.

(Continued on Page 599)

Medicare — Civil Rights Pledge

Council directed that a letter be addressed to the Director of Public Welfare, advising him of the OSMA policy on the civil rights pledge and asking him for clarification, since it is the understanding of the Association that no such pledge is required.

The Council asked that a communication be forwarded to the AMA asking what is being accomplished by that association to remove the requirement for the pledge.

Medicare — Newspaper Advertisement

An advertisement regarding Medicare, published by the Marion County Academy of Medicine, was presented to The Council for information.

Nationwide Insurance Company and Medicare

Drs. Crawford and Meredith and members of the staff reported on a conference with Nationwide Insurance officials with regard to the role of Nationwide Insurance Company as the intermediary in Ohio on Part B of Medicare. A lengthy discussion followed the report.

Legal Matter

Mr. Stichter reported to The Council on the disposition of a case brought by a member of the Association against a member of the Ohio State Bar Association.

Dirksen Amendment

A communication from Dr. E. B. Mainzer, Mansfield, regarding the Dirksen amendment was accepted by The Council for information.

Reports on Meetings

Mr. Gillen presented information with regard to the student lecture programs at the University of Cincinnati College of Medicine and Ohio State University College of Medicine and noted that such a program is scheduled for the Western Reserve University School of Medicine, May 11.

The Second National Voluntary Health Conference, Chicago, February 16-17, 1966 was attended by Mr. Gillen who reported on activities and deliberations at the conference.

Dr. Tschantz reported on the AMA Air Pollution Medical Research Conference, Los Angeles, March 2-4, 1966.

The Executive Secretary was instructed to send to the members of The Council copies of the text of a paper delivered by Francis M. Pottenger, Jr., M. D., on "What Can A County Medical Association Do About Air Pollution?" at the AMA Air Pollution Medical Research Conference in Los Angeles.

Dr. Meredith and Mr. Stichter discussed the AMA Legal Conference held in Chicago, April 16, 1966. It was pointed out that promotion material on the prevailing fee concept being encouraged by the National Association of Blue Shield Plans was distributed at the meeting. The Council **approved** a letter to the AMA, signed by Drs. Crawford and Meredith, objecting to this action and asked that copies of the communication be directed to appropriate officials of Ohio Medical Indemnity, Inc.

Mahoning County Amendment

Final approval of an amendment to the Mahoning County Constitution and Bylaws, which was adopted by that society April 19, 1966, was granted by The Council.

OSMA Major Medical Insurance

A letter from Daniels-Head & Associates, Inc., Portsmouth, dated April 20, 1966, stating that for those insureds 65 and over under the OSMA major medical expense plan, rates would be reduced because of the advent of Medicare on July 1, 1966, was reviewed by The Council.

The Executive Secretary was instructed to write a letter to Daniels-Head & Associates, Inc., asking if physicians over 65 have a choice to continue their present coverage or whether they must accept the coverage written around Medicare in view of the fact that many companies are not modifying their contracts and are making the existing coverage available for those who do not wish to participate in the Medicare program.

Conference on Medicare Regulations

The Council discussed plans for a conference of county society officers shortly after the issuance of Medicare regulations. It was felt that, if the regulations go beyond the law, an emergency Council meeting must be called and the Association's protest be made known.

The President was directed to write a letter to the Department of Health, Education, and Welfare, pointing out that, as of this date, no regulations have been issued concerning Part B of Medicare and, in addition, that there has been no indication as to when such regulations will be issued. In view of the approach of the implementation of the Medicare Act, July 1, 1966, The Council expressed the opinion that they should be published at once.

Resolution of Appreciation

On motion by Dr. Hardymon and seconded by many, The Council expressed appreciation to Dr. Tschantz for his active and effective service on The Council for the past seven years and for the dedicated leadership in the role of President and his devotion in the role of Past President.

There being no further business, The Council adjourned.

Attest: HART F. PAGE
Executive Secretary

Medical Staffing of Emergency Rooms; Legal and Ethical Considerations

By WAYNE E. STICHTER, Juris Doctor, Toledo
Legal Counsel for the Ohio State Medical Association

THE tremendous increase in the past few years in the number of cases treated in the emergency rooms of hospitals, combined with the increasing difficulty in securing personnel, professional and non-professional, to staff the emergency department, has served to focus attention upon a number of questions with respect to the staffing and operations of the emergency department:

1. Legal questions affecting the hospital and its authority over the operations of the emergency room.

2. Legal and ethical questions affecting the medical profession generally and particularly those physicians who render emergency room care.

3. Practical questions affecting the hospital, the medical profession, and the public.

In order that we may understand the nature and extent of these problems and to discuss them intelligently, it is important, so it seems to me, to have an understanding of the facts that give rise to these problems — to ascertain the causes for the critical problems existing today in connection with the rendition of high quality medical care in the emergency department of a hospital.

Years ago the emergency room of a hospital was just what the name implies — a room in the hospital for the treatment of emergency cases, a room for providing immediate medical services for acute traumatic problems and life endangering situations. The public had not yet gotten into the habit of going to the emergency room for the treatment of a minor illness or injury; rather, the patient sent for or went to his own physician. Years ago, interns and residents in training in the hospital were generally adequate in number and sufficiently competent to handle these emergency cases — with the help, of course, of the attending physicians or members of the medical staff who might be summoned to the emergency room.

Situation Today

What is the situation today? Since World War II there has been an astronomical upsurge in the number of visits to the emergency room; indeed; surveys indicate that in the past five or six years there has been an increase — on the average — of 400 to 600 per cent in the number of cases treated in the emergency room. Concurrently with this astounding **increase** in the number of emergency room cases, there has been an actual **decline** in the number of interns and residents available for the staffing of the emergency room.

We all know, of course, that in these same years there has been quite an increase in the number of traumatic injuries due to automobile accidents and perhaps other types of accidents (there has been an actual **decline** in industrial accidents). However, this increase in accidental injuries cannot possibly account for the great increase in the number of emergency room visits. The most plausible explanation for this large increase in emergency room visits lies in the fact that the hospital emergency room has gradually been converted into what one doctor has appropriately called "a neighborhood drop-in clinic." Recent statistical surveys reveal that of the total number of cases brought to the emergency room 50 to 80 per cent can be definitely characterized as **non-emergency** cases. These non-emergency cases, involving as they do minor illnesses or minor injuries, could just as well be taken care of in the physician's office. If this great volume of non-emergency cases could be diverted away from the emergency room, the present strain on the facilities and personnel of the emergency room would be greatly relieved, and the job of rendering prompt and adequate care to true emergency patients would be greatly facilitated.

Why the Emergency Room?

Why does a patient with a minor illness or injury go to the hospital emergency room instead of to the doctor's office? Various reasons have been ascribed to this change in the pattern of cases brought to the emergency room. I shall mention only a few that have been advanced:

1. There are fewer general practitioners available for family care.

Text of an address delivered by Mr. Stichter at the American Medical Association Legal Conference in Chicago on April 16, 1966.

2. The patient may not have a family doctor.

3. The patient may not know what kind of a specialist to call to take care of his particular complaint.

4. Doctors are not always available at their offices whereas the hospital emergency room is always open.

5. The necessity of an appointment with the private physician.

6. The automatic transportation of injury cases, however slight, to the emergency room (someone calls an ambulance and the ambulance driver automatically transports the patient to the hospital whether or not directed by the patient or someone in his behalf to do so).

7. A general belief that the equipment and facilities in the emergency room are more adequate and modern than those in the physician's office.

8. Physicians frequently encourage their own patients to go to the emergency room for treatment by them of the patient's minor illness or injury.

9. The major reason appears to be the public's general acceptance and seeming approval of the idea that hospital facilities—and particularly emergency room facilities — should be available for all kinds of illnesses and injuries — the idea that the hospital emergency room should be a sort of community medical center or "neighborhood drop-in clinic."

Problems in Some Areas

Regardless of the validity of any of these reasons for this tremendous increase in the number of cases coming into the emergency room, the fact remains that the overwhelming demand for medical services in the hospital emergency room has created critical problems in some areas, such as:

1. The need for enlarged emergency room quarters.

2. The need for adequate modern equipment and facilities.

3. The need for adequate staffing of competent personnel, professional and non-professional, to handle emergency cases.

4. The need to reconvert the "community medical center" or "neighborhood drop-in clinic" into a true emergency room for the care and treatment of true emergency patients. Such reconversion will involve both the education of the public to the proper function and use of the emergency room, and the cooperative effort of hospital and medical personnel in the reference of non-emergency cases to the private practitioner, medical clinic or the out-patient department. This will also involve a complete separation of the emergency room department from the out-patient department.

All of these needs must be met. The public rightfully demands (and is entitled to) the rendition of high-quality medical care and the maintenance of emergency rooms which have the facilities needed for the prompt rendition of medical services by a staff of licensed physicians. Assuredly, the medical profession wants to see these rightful demands met. In meeting these demands, it is important to keep in mind two things: (1) the separate and distinct functions of the hospital and the medical practitioner, and (2) the fact that the proper and efficient operation of emergency room service requires close cooperation between the hospital and the medical profession in the performance of their separate functions. Each needs the other. The hospital cannot **lawfully** practice medicine. The medical profession cannot **effectively** practice medicine **without the use of hospital facilities** and non-professional personnel of the hospital.

Separate Functions and Responsibilities

The furnishing of the physical equipment and facilities of the emergency room, the furnishing of necessary non-professional personnel, and the general administration and operation of the emergency room, are the proper function and responsibility of the hospital.

On the other hand, the rendition of professional services in the emergency room is the exclusive right and responsibility of the medical profession; such professional services may legally be rendered only by duly qualified physicians directly or by hospital personnel under the direct supervision and control of the physicians. The hospital has no legal right to direct, control or supervise the rendition of any services which are of a professional character, regardless of whether such services are rendered by the hospital's non-professional employees, or by its salaried physicians, or by physicians under contract with the hospital; and any attempt by the hospital to direct, control or supervise such services would constitute, in my judgment, the unlawful practice of medicine. Furthermore, even though the hospital should not attempt to direct, control or supervise the rendition of professional services in the emergency room, the hospital would nevertheless be engaged in the unlawful practice of medicine **if it receives the whole or any part of the fee charged for such professional services, or if the hospital otherwise derives any profit, financial gain or benefit from the rendition of such services.**

Principles of Medical Ethics

It should also be mentioned here that a physician who permits fee-splitting with the hospital, or who renders professional services (in the emergency room or elsewhere in the hospital for that matter) under an arrangement whereby the hospital derives some

profit, financial gain or benefit, is guilty of a violation of the *Principles of Medical Ethics.*

In this connection, I call attention to Sections 6 and 7 of the *Principles of Medical Ethics* of the American Medical Association.

Section 6 reads:

"A physician should not dispose of his services under terms or conditions which tend to **interfere with or impair the free and complete exercise of his medical judgment and skill** or **tend to cause a deterioration of the quality of medical care.**"

Section 7 reads:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. **He should neither pay nor receive a commission for referral of patients.** Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

These sections have been interpreted by the Judicial Council of the AMA as forbidding the following:

1. Any interference by a hospital with the free and complete exercise of the physician's medical judgment or skill through any direction, control or supervision by a hospital over the physician's performance of medical services.

2. The receipt and retention by the hospital of the whole or any part of a fee paid for professional services rendered by a physician employed by the hospital on a salary basis or other contract basis, regardless of whether such payment is made to the physician and a part thereof delivered over to the hospital or whether the fee is paid to the hospital and the whole or a part thereof is retained by the hospital.

Explicit Understanding

How, then — it may be asked — can the demands of the medical public for adequate emergency room services be met without involving the hospital in the unlawful practice of medicine or involving the emergency room staff of physicians in a violation of the *Principles of Medical Ethics?* I submit that this can be accomplished by a clear, explicit understanding between the hospital and the emergency room physicians as to (1) the legal limitations on the functions and activities of the hospital, and (2) the ethical limitations that are imposed on all practicing physicians by the Principles of Medical Ethics, coupled with a willing obedience to these legal and ethical principles by the hospital and the emergency room physicians, respectively.

In this connection, it must be borne in mind that the **unlawful** practice of medicine by a **hospital** is usually accomplished through or by means of the **unethical** practice of medicine by the **physician.** It thus becomes readily apparent that if every physician will carefully refrain from entering into any arrangement with a hospital (1) which involves fee-splitting, or (2) which involves the obtaining by the hospital of some profit or other financial gain or benefit from the professional services of the physician, or (3) which subjects the physician to any direction, control or supervision by the hospital over his professional judgment — the practice of medicine by hospitals will be greatly reduced and, perhaps, eventually eliminated.

Contractual Arrangements

There are several forms of contractual arrangements for the staffing and operation of the emergency room which, if properly implemented and conscientiously adhered to, will not involve the hospital in the practice of medicine or expose the physician to a charge of violating the Principles of Medical Ethics. These may be summarized as follows:

Arrangement #1. This would provide for the rendition of services by use of bona fide interns and residents in AMA-Approved Emergency Room Training Programs, under the active guidance of the medical staffs. Under this plan, no charge would be made by the hospital for the professional services so rendered and no part of any fee that might be collected from the patient would be shared by the hospital.

Arrangement #2. Services would be rendered on a fee-for-service basis by several practicing physicians who would be approved by the medical staff with a minimum monthly compensation guaranteed by the hospital As in Arrangement #1, no charge would be made, or fee collected or shared, by the hospital for any such professional services.

Arrangement #3. Services would be rendered by members of the medical staff either on a voluntary or mandatory assignment, and on a fee-for-service or gratuitous basis with billing, if any, direct by the physician for such professional services. Again, no charge would be made by the hospital for such services and there would be no splitting of fees as between the physician and hospital.

Arrangement #4. This provides for services to be rendered by several practicing physicians (employed by a medical partnership or a medical corporation) who would be approved by the medical staff. The billing and remuneration for such professional services would be the prerogative and responsibility of the medical partnership or corporation and the employed physicians. In no event would any charge be made, or fee collected or shared, by the hospital for any such professional services.

There is another form of contractual arrangement which might pass muster but which I think less desir-

able than the four forms of arrangements I have just mentioned. We shall call this "Arrangement #5." Under this Arrangement, services would be performed by one or more licensed physicians approved by the medical staff and employed by the hospital on a salary basis. Such services would be rendered without any charge being made by the hospital, or any fee collected or shared by the hospital, for such professional services. Further, there would not be included in the hospital's bill for hospital services any charge whatever for the professional services of the salaried physician. I consider this Arrangement #5 much less desirable because I think it is too much to expect that the hospital would pay a fair and reasonable salary without expecting and obtaining some financial benefit — by way of fee-splitting or otherwise — from the professional services of the salaried physician.

Consideration of Needs

Each of these five arrangements or methods seems unobjectionable from the standpoint of legality and medical ethics. The selection of any particular method of staffing the emergency room will depend, I think, on the particular needs of the community and the particular conditions under which a group of physicians is willing to undertake the responsibility of staffing. Obviously, that method should be selected which promises to do the best job in the community (a) in rendering high quality medical care to emergency patients, and (b) in preserving and promoting the best possible relation between the profession and the hospital, between physician and physician, and between the medical profession and the public. Other things being equal, that method should be selected which affords the least opportunity — the least temptation — to the hospital and physician to indulge in practices which are unlawful from the standpoint of the hospital or unethical from the standpoint of the physician.

While each one of these several contractual arrangements, if conscientiously adhered to by the hospital and the emergency room physician, should prove effective in preventing the encroachment of hospitals upon the practice of medicine, there are other important factors that must be given serious consideration in the development of a successful hospital emergency room plan. In the first place, it is of the utmost importance, I think, that the hospital emergency room program have the full approval and support of the private practitioners in the community.

Medical Society Responsibility

We all know that it is the responsibility of the medical profession to see to it that adequate, high quality medical care is rendered at all times, in all places, to all patients. Consequently, the local medical society has, or should have, a decided interest as well as a professional duty with respect to the details of any plan for the staffing and operation of a hospital emergency room. The local society owes a duty to the public as well as to the local profession to ascertain whether the emergency room program will be implemented in such fashion as to insure the rendition of high quality emergency care. At the same time, it has the right, and it also owes the duty to the practicing physicians in the community, to insist that the activities of the emergency room staff be confined, as a general rule, to the treatment of true emergency cases to the end that there may be preserved complete confidence, respect, and harmony as between the members of the emergency room staff and private practitioners.

Evaluating an Emergency Room Plan

It is my belief that any contract, arrangement or plan for the staffing and operation of a hospital emergency room should be carefully analyzed and evaluated by the local society before the plan is finalized and put into effect. Any such plan might well be tested and evaluated on the basis of the answers to the following questions:

1. Is the plan such as to give assurance of the rendition of high quality medical care in true emergency cases on a round-the-clock basis?

2. Will the responsibility, control and direction of professional services in the emergency room be kept exclusively in the hands of the medical profession?

3. Will the group of physicians staffing the emergency room have the respect and confidence of the local society and of the profession generally, both with respect to the competence of the group and with respect to their ethics and integrity?

4. Does the plan provide that the physicians staffing the emergency room will limit their services and activities to true emergency cases and will render emergency services to a patient only if the patient's own physician is unknown or is not immediately available?

5. Will the treatment by the emergency room group of an emergency case be limited to such initial treatment as the emergency case requires?

6. Will the emergency room staff, as a matter of course, refer each emergency patient to his own physician for necessary follow-up care?

7. Will each non-emergency patient be referred to his own physician without treatment by the emergency room group except perhaps for necessary first aid? If the patient has no family physician, will the patient be afforded freedom of choice of physician — freedom to choose either a member of the emergency room group or some other physician? Will the emergency room group be circumspect regarding this matter so as to maintain the confidence, respect and esteem of their confreres in private practice?

Official OSMA Policy Statement On Staffing Emergency Rooms

Acting on recommendations of the OSMA Hospital Relations Committee, The Council at its March 20 meeting adopted the statement printed below as the official policy of the Association:

The following are recommended as acceptable methods for the medical staffing of emergency rooms:

1. Services by use of bona fide interns and residents in AMA-approved training programs, under the active guidance of the Medical Staff:

2. Services on a fee-for-service basis by one or more licensed physicians approved by the Executive Committee of the Medical Staff of the hospital, with a minimum compensation guaranteed in a manner satisfactory to the Medical Staff.

3. Services by members of the Medical Staff, either voluntary or mandatory, on a fee-for-service or gratuitous basis, with the method of billing for professional services being direct billing by the physician for his services.

4. Services by licensed physicians employed by a medical partnership or corporation, approved by the Executive Committee of the Medical Staff, and composed of all or part of the members of the Medical Staff, billing and remuneration for such professional services to be on any mutually satisfactory arrangement between the medical partnership or corporation and the employed physicians.

8. Will the plan have the approval and cooperation of the local medical society and the medical profession generally?

It is obvious, I think, that the **ideal** emergency room plan will provide **affirmative** answers to **each** of these questions.

Interest of the Public

In the final analysis, the best interests of the public will be served, the best interests of the hospital will be served, and the best interests of the medical profession will be served if the emergency room plan clearly delineates, in writing, the respective functions, rights, responsibilities and obligations of the hospital and the physician. Regardless of the particular method selected for the staffing and operation of the hospital emergency room, the contractual arrangement between the hospital and each emergency room physician should be such as

(a) will allow the physician to retain his professional integrity and independence;

(b) will leave unimpaired the physician's right to the free and complete exercise of his medical judgment;

(c) will recognize the physician's right to fix, collect and retain the entire amount of his fee for professional services rendered to patients in the emergency room — without any fee-splitting of any sort or the deriving by the hospital of any profit, financial gain or benefit, directly or indirectly, from the professional services rendered by the physician; and

(d) will preserve and promote the best of relations between the medical profession and the hospital, between the emergency room staff physicians and their confreres, and between the medical profession and the public.

Resolution Expresses Appreciation For Service on Medical Board

Upon his recent retirement from the State Medical Board of Ohio, Dr. John N. McCann, of Youngstown, was accorded the following resolution in appreciation of his service. The resolution was forwarded to *The Journal* by Dr. Donald F. Bowers, Columbus, member of the Board and interim secretary.

RESOLUTION

WHEREAS, John N. McCann, M. D., has faithfully and well performed his duties as a member of the State Medical Board for the past 21 years and

WHEREAS, The State Medical Board of Ohio is aware of the long and faithful service, devotion, dedication and interest to the Board and to the State of Ohio as well as to the medical profession and patients, and

WHEREAS, The State Medical Board of Ohio desires to express its gratitude to John N. McCann, M. D., for his services,

NOW BE IT RESOLVED BY THE STATE BOARD OF OHIO, That the Board on behalf of itself and the State of Ohio extends its thanks and best wishes to John N. McCann, M. D., for his 21 years of faithful service to the Board and to the State of Ohio.

Columbus, Ohio, this
5th day of April, 1966.

(Signed by the eight members of the Board)

Dr. Lloyd R. Evans, Columbus, was named by the Governor to succeed Dr. McCann on the Medical Board. (See May issue of *The Journal,* page 521.)

Ray Bruner, *Toledo Blade* science writer, was given special commendation in the newspaper category by the judging committee of the American Medical Association's 1965 Journalism Awards Contest.

IN MATTERS OF CREDIT

. . . one of these 86 is close to you . . . can help you save credit losses and profits

AKRON CREDIT BUREAU, INC.
53 West State Street, AKRON
CREDIT BUREAU OF ALLIANCE
611 City Savings Bldg., ALLIANCE
CREDIT BUREAU OF ASHLAND, INC.
159 West Main St., ASHLAND
CREDIT BUREAU OF ASHTABULA
132 West 46th St., ASHTABULA
CREDIT BUREAU OF ATHENS
2 South Congress St., ATHENS
BARBERTON AREA CREDIT RATING BUREAU
539-½ W. Tuscarawas Ave., BARBERTON
CREDIT BUREAU OF CLERMONT COUNTY
285 Main St., BATAVIA
CREDIT BUREAU OF LOGAN COUNTY
111 S. Madriver, BELLEFONTAINE
CREDIT BUREAU OF BELLEVUE
202 W. Main St., BELLEVUE
CREDIT BUREAU OF BOWLING GREEN, WOOD AND HENRY COUNTIES
802 E. Wooster St., BOWLING GREEN
CREDIT BUREAU OF WILLIAMS COUNTY
204 W. Bryan St., BRYAN
BUCYRUS CREDIT BUREAU
Eagle Building, BUCYRUS
CREDIT BUREAU OF NOBLE COUNTY
722 West St., CALDWELL
CAMBRIDGE CREDIT BUREAU
220 N. Eighth St., CAMBRIDGE
CREDIT BUREAU OF CANTON
128 Third St., N.E., CANTON
CREDIT BUREAU OF CHILLICOTHE
15 W. Second St., CHILLICOTHE
CREDIT BUREAU OF CINCINNATI, INC.
309 Vine St., CINCINNATI
CREDIT BUREAU OF CIRCLEVILLE
219 S. Court St., CIRCLEVILLE
CREDIT BUREAU OF CLEVELAND, INC.
1965 E. 6th St., CLEVELAND
CREDIT BUREAU OF COLUMBUS, INC.
170 E. Town St., COLUMBUS
CREDIT BUREAU OF CONNEAUT
247-½ Main St., CONNEAUT
CREDIT BUREAU OF COSHOCTON
439-½ Main St., COSHOCTON
CREDIT BUREAU OF DAYTON, INC.
115 E. Third St., DAYTON
CREDIT BUREAU OF DEFIANCE, WILLIAMS, FULTON & PAULDING COUNTIES
509 Second St., DEFIANCE
CREDIT BUREAU OF DELAWARE
Delaware County Bank Bldg., DELAWARE
CREDIT BUREAU OF PREBLE COUNTY
208 N. Barron St., EATON
ELYRIA CREDIT BUREAU, INC.
360 Second St., ELYRIA
CREDIT BUREAU OF HANCOCK COUNTY
118 E. Sandusky St., FINDLAY
CREDIT BUREAU OF FOSTORIA
215 First Nat'l. Bank Bldg., FOSTORIA
CREDIT BUREAU OF FREMONT, INC.
316-½ W. State St., FREMONT
CREDIT BUREAU OF GALION
Quay Building, GALION
CREDIT BUREAU OF GALLIA & MEIGS COUNTIES
530-½ Second Ave., GALLIPOLIS
CREDIT BUREAU OF NORTHEASTERN OHIO
104 W. Main St., GENEVA
CREDIT BUREAU OF BROWN COUNTY
First Nat'l Bank Bldg., GEORGETOWN
CREDIT BUREAU OF DARKE COUNTY
Fourth & Broadway, GREENVILLE
REPORTING SERVICE INC.
250 High St., HAMILTON
CREDIT BUREAU OF HIGHLAND COUNTY
106-½ N. High St., HILLSBORO
IRONTON CREDIT BUREAU, INC.
206 Masonic Temple, IRONTON
CREDIT BUREAU OF JACKSON
202-½ Broadway, JACKSON
CREDIT BUREAU OF NORTHEASTERN OHIO
944 Stow St., KENT
CREDIT BUREAU OF KENTON, INC.
221-½ W. Franklin, KENTON
CREDIT BUREAU OF LANCASTER
210 Fairfield Bldg., LANCASTER
LEBANON CREDIT BUREAU
151-½ S. Broadway, LEBANON
CREDIT BUREAU OF LIMA
205 W. Market St., LIMA
CREDIT BUREAU OF LONDON & MARYSVILLE
16 W. High St., LONDON
CREDIT BUREAU OF LORAIN, INC.
314 Ninth St., LORAIN
MANSFIELD CREDIT RATING BUREAU
28 Park Ave. West, MANSFIELD
THE CREDIT BUREAU
303 St. Clair Bldg., MARIETTA
MARION CREDIT RATING CO. INC.
142 E. Center St., MARION
CREDIT BUREAU OF MASSILLON, INC.
810 Peoples Merchants Bldg., MASSILLON
MEDINA COUNTY CREDIT BUREAU, INC.
215 W. Liberty St., MEDINA
CREDIT BUREAU OF NORTHEASTERN OHIO
14944 S. Main St., MIDDLEFIELD
THE MIDDLETOWN CREDIT BUREAU CO.
508 First Nat'l Bank Bldg., MIDDLETOWN
CREDIT BUREAU OF KNOX COUNTY
102 E. Gambier St., MOUNT VERNON
CREDIT BUREAU OF NEWARK
Schaus Bldg., NEWARK
CREDIT BUREAU OF PERRY COUNTY
218 N. Main St., NEW LEXINGTON
CREDIT BUREAU OF NEW PHILADELPHIA AND DOVER
162 N. Broadway, NEW PHILADELPHIA
CREDIT BUREAU OF NILES
409 Niles Bank Bldg., NILES
CREDIT BUREAU OF NORWALK, INC.
18 W. Main St., NORWALK
CREDIT BUREAU OF OBERLIN, INC.
5 South Main St., OBERLIN
PUTNAM CREDIT BUREAU
1035 E. Second St., OTTAWA
CREDIT BUREAU OF PAINESVILLE
41 E. Erie St., PAINESVILLE
CREDIT BUREAU OF MIAMI COUNTY
118 West Ash St., PIQUA
CREDIT BUREAU OF PORT CLINTON
426 W. Sixth St., PORT CLINTON
THE MERCHANTS CREDIT BUREAU, INC.
413 Masonic Temple, PORTSMOUTH
CREDIT BUREAU OF SALEM, INC.
368 E. Third St., SALEM
CREDIT BUREAU OF ERIE COUNTY, INC.
808 Feick Bldg., SANDUSKY
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34 E. Main St., XENIA
CREDIT BUREAU OF YOUNGSTOWN, INC.
125 W. Commerce St., YOUNGSTOWN
CREDIT BUREAU OF ZANESVILLE
135 S. Sixth St., ZANESVILLE

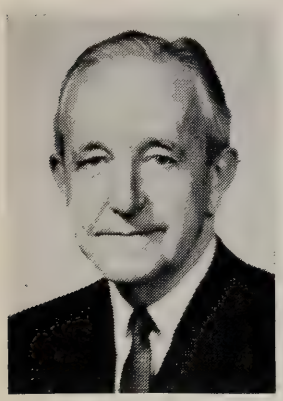
ASSOCIATED CREDIT BUREAUS OF OHIO

AMA Annual Convention . . .

Ohio's Dr. Hudson To Be Installed as the 121st President; All-Inclusive Program Scheduled in Chicago, June 26 - 30

OHIOANS will have a special interest in the 115th Annual Convention of the American Medical Association in Chicago, June 26-30. On that occasion an Ohioan will be installed as President — the highest honor the medical profession can bestow on one of its members.

The inauguration of Dr. Charles L. Hudson, of Cleveland, as the 121st President of the AMA will be held on Tuesday afternoon, June 28, beginning at 4:00 P. M. in the Grand Ballroom of the Palmer House. The ceremonies are open to all registrants.



Dr. Hudson

Dr. Hudson was named President-Elect at the 1965 Annual Convention in New York City. He previously served on the AMA Board of Trustees, was for a number of years delegate from the OSMA to the AMA, is a Past President of OSMA, a Past President of the Cleveland Academy, and served the medical profession in many other capacities. A practicing physician of long standing in Cleveland, Dr. Hudson specializes in internal medicine.

The world's largest medical meeting, the Annual Convention of the American Medical Association, is expected to draw an attendance of 45,000, including some 15,000 physicians.

The program is outlined in a special section of the May 9 *Journal of the AMA.* A diverse scientific program covering virtually every medical specialty will be presented. The AMA's policy-making House of Delegates will meet in the Palmer House hotel, and more than 350 scientific exhibits will be housed in McCormick Place convention center.

McCormick Place also will be the site of many scientific sessions and an extensive medical motion picture and television program. The telecasts will originate from the University of Illinois College of Medicine, University Hospitals, Chicago.

Topics of the six general scientific sessions include emphysema, population expansion, burns, mysterious fevers, community hospitals and coronary care units, and headaches.

Another highlight will be the Sixth Multiple Discipline Research Forum. Topics will include hematology, immunology and tumor; gastrointestinal problems; metabolism and renal diseases; neurology and pulmonary diseases, and cardiovascular subjects.

The AMA House of Delegates will convene at 3 p. m. Sunday, June 26, in Arie Crown Theater at McCormick Place. Speaker of the House is Milford O. Rouse, M. D., of Dallas, Texas.

The scientific program will open at 9 A. M. Monday, June 27, in McCormick Place. Scientific and industrial exhibits will open at 10 A. M. Sunday, June 26, in McCormick Place, and will be open Monday through Thursday from 8:30 A. M. to 5 P. M.

General registration will be in the lower lobby of McCormick Place. It will open 10 A. M. Sunday, and will be open from 8:30 A. M. to 5 P. M. on following days.

Among preconvention activities is the Conference of State Medical Society Presidents and Secretaries scheduled to begin at 9:30 A. M. on Sunday, June 26, in the Palmer House.

A listing of other special events is included in the May 9 issue of *JAMA,* beginning on page 515. The Woman's Auxiliary program is printed in the same issue, beginning on page 518.

Here Are More Features

The American College of Chest Physicians will again join the AMA Section on Diseases of the Chest in an all day program.

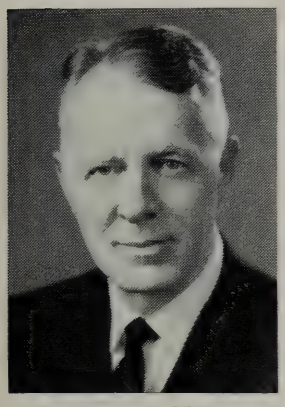
The American College of Cardiology and the American Heart Association will join the AMA Section on Internal Medicine in a half-day session.

The American Congress of Physical Medicine and Rehabilitation and the Mid-America Society of Physical Medicine and Rehabilitation will meet jointly with the Section on Physical Medicine.

The American Society of Clinical Pathologists will join the AMA Section on Pathology and Physiology in a half-day session on Computers in Medicine.

OSMA Announces Candidacy of Cleveland Physician For the Office of AMA House Vice-Speaker

THE Ohio State Medical Association has announced through official medical organization channels that it will place in nomination for the office of Vice-Speaker of the American Medical Association House of Delegates, Dr. John H. Budd, of Cleveland. The nomination will be made at the 1966 Annual Convention of the AMA in Chicago, June 26-30.



Dr. Budd

In announcing Dr. Budd's candidacy, Dr. Theodore L. Light, Dayton, and Dr. George W. Petznick, Cleveland, cochairman of the campaign committee, write in part as follows:

"We are quite certain that, if you have been in attendance at the regular and special sessions of the House of Delegates in the past four crucial years, you are aware of Dr. Budd's leadership in that body and his earnest efforts to establish and maintain policies that will preserve the private, free enterprise system of medical practice.

"He often has spoken on the floor of the House of Delegates and in reference committee hearings as to the importance of adherence to the established policies of the House.

"Dr. Budd is a family physician engaged in the private practice of medicine in Cleveland, Ohio. He has served as Chairman of the Ohio Delegation to the AMA since 1962 and has been a Delegate since 1960.

"He is the author of the Nine Standards for Health Programs, adopted by the AMA House of Delegates in February, 1965. These standards are an example of Dr. Budd's earnest defense of principle. — — —"

The Council, by official action, directed the OSMA delegation to the AMA to place Dr. Budd's name in nomination.

On the national level, Dr. Budd has been a delegate to the AMA since 1960, and chairman of the Ohio delegation since 1962. He is a member of the AMA Planning and Development Committee, and a member of the AMA Speakers' Bureau.

He has been a member of the OSMA Committee on Public Relations and Economics since 1958; was chairman of the OSMA Ad Hoc Ohio Medical Indemnity Study Committee, and has long served as chairman of one of the OSMA House of Delegates Committees on Resolutions.

He is a Past President of the Academy of Medicine of Cleveland and a former member of its Board of Directors. Also he has been a delegate of the Cleveland Academy to OSMA since 1948. His leadership in other local and area activities and his participation on various Academy committees are too numerous to relate in detail.

Dr. Budd is a private practitioner in Cleveland and a member of the American Academy of General Practice. During World War II he received several battle awards for service in Europe, Africa and the Middle East.

He is one of four physicians given special honors by the Cleveland Academy of Medicine at the Academy's Annual Meeting May 13.

Tour of AMA Headquarters A Convention Highlight

Special feature of the American Medical Association's 115th Annual Convention will be a guided tour of AMA headquarters at 535 North Dearborn Street and the new Institute for Biomedical Research.

All physicians, their wives and other convention guests are invited to tour the building. Tours will be conducted every hour from 9 A. M. to 4 P. M., Monday, June 27 through Friday, July 1.

A special corps of guides will escort the visitors and answer any questions regarding AMA publications, services and activities.

* * *

Among features at the 115th Annual Convention, the International Academy of Pathology will join the Section on Pathology and Physiology in a full day's program on Tropical Medicine.

* * *

The AMA Committee on Blood and the Section on General Practice will present a half-day session.

* * *

The Society for Investigative Dermatology, Inc. will hold its meetings in conjunction with the Section on Dermatology, and the Association for Research in Ophthalmology, Inc. in conjunction with the Section on Ophthalmology.

REPORT ON EXAMINATION OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1965, OF OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the statement of assets of the Ohio State Medical Association at December 31, 1965, and the related statement of cash receipts and disbursements of the Executive Secretary and the Treasurer and the statement of operations of The Journal for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The statements of the Journal included herein have been prepared on the accrual basis of accounting. The statements of the Executive Secretary and the Treasurer included herein have been prepared on the cash receipts and disbursements basis, and, as a result, include as income 1966 membership dues of $86,522.50. Under generally accepted accounting principles, such dues would be deferred at December 31, 1965 and included in income during 1966. Accordingly, the statements as a whole do not in our opinion, present financial position and results of operations as they would appear had generally accepted accrual basis accounting principles been applied in their preparation.

In our opinion, the accompanying statement of assets at December 31, 1965, and the related statement of cash receipts and disbursements and the statement of operations for the year then ended present fairly the information set forth therein and have been prepared on a basis consistent with that of the preceding year.

Lybrand, Ross Bros. & Montgomery

Columbus, Ohio,
March 16, 1966

OHIO STATE MEDICAL ASSOCIATION

Statement of Assets, December 31, 1965

	Total	Executive Secretary's Account	Treasurer's Account	The Journal
Cash in bank and petty cash	$ 84,212.62	$ 61,342.63	$ 20,788.42	$ 2,081.57
Cash in savings account	75,869.54		75,869.54	
United States Government obligations, at cost	75,000.00		75,000.00	
Accounts receivable — advertisers, less allowance for doubtful accounts of $727.00	9,234.76			9,234.76
Deposit on postage	160.00			160.00
Office equipment, at cost less accumulated depreciation of $30,098.99	18,050.17			18,050.17
	$262,527.09	$ 61,342.63	$171,657.96	$ 29,526.50

OHIO STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year ended December 31, 1965

	Total	Executive Secretary's Account	Treasurer's Account
Cash in bank, beginning of year	$118,537.60	$ 87,429.03	$ 31,108.57
Cash receipts:			
1966 Membership dues	86,522.50	86,522.50	
1965 Membership dues	244,292.50	244,292.50	
Interest on savings deposits	3,526.22	3,526.22	
Interest on United States Government obligations	3,095.78		3,095.78
Exhibit space, 1965 annual meeting	17,805.00		17,805.00
Exhibit space, 1966 annual meeting	7,910.00		7,910.00
Fees for collection of A. M. A. dues	3,396.15		3,396.15
	$366,548.15	$334,341.22	$ 32,206.93
Interaccount transfers (principally 1965 dues)		(360,427.62)	360,427.62
Cash disbursements:			
Ohio State Medical Journal	47,920.00		47,920.00
Salaries; and expenses (Staff, Officers, Council)	152,762.73		152,762.73
Professional conferences and scientific meetings	65,850.37		65,850.37
Committee expenses	14,639.14		14,639.14
Department of Public Relations	27,756.89		27,756.89
Employees' benefits	21,693.85		21,693.85
Contributions	7,987.05		7,987.05
General	64,344.67		64,344.67
	402,954.70		402,954.70
Cash in bank, end of year	$ 82,131.05	$ 61,342.63	$ 20,788.42
Cash in savings accounts, beginning of year	$ 72,868.72		$ 72,868.72
Interest received	3,000.82		3,000.82
Cash in savings accounts, end of year	$ 75,869.54		$ 75,869.54

THE OHIO STATE MEDICAL JOURNAL

Statement of Operations, Year ended December 31, 1965

Income:		
Advertising, Net	$ 50,618.42	
OSMA appropriation	47,920.00	
Subscriptions	1,295.00	$ 99,833.42
Expense:		
Salaries	$ 29,267.50	
Journal printing	59,810.53	
Other (includes depreciation of $1,911.47)	11,509.17	100,587.20
Net loss		$ 753.78

Control of Infections . . .

Conference on Prevention and Control of Infections in Health Care Facilities Scheduled in Columbus, June 22-24

NINE ORGANIZATIONS with interest in the subject are cosponsoring **A Conference on Prevention and Control of Infections in Health Care Facilities** at the Sheraton-Columbus Motor Hotel in downtown Columbus, Wednesday, Thursday, and Friday, June 22, 23, and 24.

The conference is designed for administrators of health care facilities — hospitals, institutions, nursing homes, physicians, nursing directors and instructors in health care facilities, health commissioners and health department personnel responsible for health care programs, and faculty members for medical and nursing schools.

Cosponsors are the Ohio Department of Health, Ohio Department of Mental Hygiene and Correction, Ohio Hospital Association, Ohio Nursing Home Association, Ohio State Medical Association, Ohio State Nurses Association, Ohio Osteopathic Association of Physicians and Surgeons, the Ohio State University College of Medicine, and the U. S. Department of Health, Education and Welfare.

Registration opens at 9:00 A. M., on June 22 and the conference runs through noon on June 24. There is no charge for the course, but a registration fee of $5.00 will cover incidental expenses.

Following are features of the program:

Welcome — Calvin B. Spencer, M. D., acting chief, Division of Communicable Disease, Ohio Department of Health.

Introduction to the Conference — Bernard A. Brown, D. V. M., Health Professions Training Section, Communicable Disease Center, Atlanta, Ga.

What Is the Extent of the Hospital Infections Problem with Its Varying Etiology? — Martin D. Keller, M. D., associate professor of preventive medicine and assistant professor of medicine, Ohio State University.

Implications and Liabilities of Infections Control — Nathan Hershey, LL. B., associate director of Health Law Center, University of Pittsburgh.

An Effective Infections Control Committee; Its Organization, Functions, Channels, and Problems — Clifton K. Himmelsbach, M. D., chairman, Committee on Infections Within Hospitals, American

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MAIL APPLICATION TO:

Calvin B. Spencer, M. D.
Acting Chief, Division of Communicable Diseases
Ohio Department of Health
P. O. Box 118
Columbus, Ohio 43216

Please consider me for enrollment in the training course, "Prevention and Control of Infections in Health Care Facilities" — June 22, 23, 24, 1966, at the Sheraton-Columbus Motor Hotel, Columbus, Ohio.

NAME.....

TITLE.....

ORGANIZATION.....

ADDRESS.....

☐ Enclosed is my check for the registration fee of $5.00 made payable to, Dr. Calvin B. Spencer, Chairman.

Hospital Association, and associate dean for research, Georgetown University Medical and Dental Schools.

What Is Your Infection Rate? Designing Surveillance Systems — Theodore C. Eickhoff, M. D., deputy chief of the Investigation Section, Epidemiology Branch, Communicable Disease Center, Atlanta, Georgia.

Patients and Personnel with Overt and Inapparent Infections; Patient Information and Isolation Procedures; Management of Information — Dr. Himmelsbach.

Coordination and Continuity in the Infections Committee Through a Permanent Member:

Physician Hospital Epidemiologist in 38 New York City Hospitals — Harry S. Lichtman, Borough chief, Bureau of Preventable Disease, New York City Department of Health;

Nurse Hospital Epidemiologist in Reporting and Coordination — Shirley J. Streeter, R. N., assistant director of nursing, Research and Education Hospital, University of Illinois.

Administrative Actions and Costs in the Control of Infections — Roy J. Weinzettel, administrator, Memorial Hospital of Chatham County, Savannah, Georgia.

Essential Laboratory Services — Colin R. Macpherson, professor and vice - chairman, Department of Pathology, Ohio State University.

Monitoring Inanimate Environment—George F. Mallison, chief, Biophysics Section, Communicable Disease Center, Atlanta, Ga.

Design and Modification for Environmental Control — Wilbur R. Taylor, assistant chief, Architectural, Engineering and Equipment Branch, Hospital and Medical Facilities Division, PHS, Washington, D. C.

Motivation for Personnel Action — William H. Hale, Ph. D., associate director, Georgia Center for Continuing Education, University of Georgia.

Note the attached registration application form. Additional information also may be obtained from Dr. Spencer at the address indicated on the application form.

Malpractice Insurance Rates...

Approximately Ten Per Cent Increase in Most Classifications Authorized for National Bureau Companies, Effective June 1

WHAT AMOUNTS to an average ten per cent increase in professional liability insurance rates charged to Ohio physicians and surgeons by companies belonging to the National Bureau of Casualty Underwriters has been authorized by the Ohio Department of Insurance, effective June 1.

Following are old and new scales of rates for basic $5,000 - $15,000 coverage, as released by William R. Morris, director of the Ohio Department of Insurance:

Class No. 1 Physicians:
Old rate, $38.00; new rate, $42.00.

This classification applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and who do not ordinarily assist in surgical procedures. Specialists referred to in this classification are: allergists, cardiologists (not including catheterization), dermatologists, gastroenterologists, industrial medicine, internists, neurologists, pathologists, pediatricians, preventive medicine, psychiatrists, public health, physiatrists and roentgenologists - radiologists.

Class No. 2 Physicians:
Old rate, $48.00; new rate, $53.00.

This classification applies to general practitioners and specialists who perform minor surgery (including obstetrical procedures not constituting major surgery) or assist in major surgery on their own patients. Tonsillectomies, adenoidectomies, and cesarean sections are considered major surgery. The specialists referred to are the same as those listed in Class No. 1.

Class No. 3 Surgeons:
Old rate, $91.00; new rate, $101.00.

This classification applies to general practitioners who perform major surgery or assist in major surgery on other than their own patients and certain specialists. The specialists referred to are: cardiologists (including catheterization, but not including cardiac surgery) ophthalmologists, and proctologists.

Class No. 4 Surgeons:
Old rate, $137.00; new rate, $151.00.

This classification applies to the following specialists: anesthesiologists, cardiac surgeons, neurosurgeons, obstetricians - gynecologists, orthopedists, otolaryngologists, plastic surgeons, general sur-

geons, thoracic surgeons, urologists and vascular surgeons.

Physicians and Surgeons in active U. S. military service:

Class No. 1 Physicians:
Old rate, $15.00; new rate, $15.00

Class No. 2 Physicians:
Old rate, $19.00, new rate $19.00

Class No. 3 Surgeons:
Old rate, $36.00; new rate, $36.00

Class No. 4 Surgeons:
Old rate, $54.00; new rate, $54.00

X-ray therapy:
Old rate, $15.00; new rate, $15.00

Shock therapy:
Old rate, $15.00; new rate, $15.00

Additional charges which apply to all the foregoing classifications except physicians in active military service:

*Employed physicians as defined in Class No. 1:
Old rate, $9.50; new rate, $10.50

*Employed physicians as defined in Class No. 2:
Old rate, $12.00; new rate, $13.50

*Employed surgeons as defined in Class No. 3:
Old rate, $23.00; new rate, $25.50

*Employed surgeons as defined in Class No. 4:
Old rate, $34.50; new rate, $38.00

*Employed technicians (radium, laboratory, or pathological):
Old rate, $5.00; new rate, $5.00

*Employed technicians (X-ray therapy):
Old rate, $13.00; new rate, $13.00

Partnership liability: 20% of the per person rate for each individual comprising the partnership

*Shock therapy, by employed physicians or surgeons:
Old rate, $12.00; new rate, $13.50

Shock therapy, by insured physicians or surgeons:
Old rate, $48.00; new rate, $53.00

*X-ray therapy, by employed physicians or surgeons:
Old rate, $12.00; new rate, $13.50

X-ray therapy, by insured physicians as defined in Class No. 1 or Class No. 2:
Old rate, $48.00; new rate, $53.00

X-ray therapy, by insured physicians or surgeons as defined in Class No. 3 or Class No. 4:
Old rate, $48.00; new rate, $53.00

* NOTE: This rate applies not only to employees of individual insureds but also to employees of partnerships. It applies per employee regardless of the number of partners. It applies also to such personnel in pathological or x-ray laboratories operated or supervised by the insured in hospitals, whether or not employees of the insured.

Ohio Physicians Are Appointed To AMA Committee Posts

George J. Hamwi, M. D., Columbus, has been elected chairman of the Council on Foods and Nutrition of the American Medical Association.

Previously, Dr. Percy E. Hopkins, chairman of the AMA's Board of Trustees, announced Dr. Hamwi's reappointment to the Council.

The AMA Council consists of 11 authorities in the field of nutrition appointed by the Board of Trustees. These members represent medicine and allied sciences such as biochemistry, physiology and food technology. The Council's current interests include continuing medical education in nutrition, improvement of nutrition teaching in medical schools, and promotion of rational diet therapy through council statements and reports.

Dr. Hamwi is a Past President of the Ohio State Medical Association. He is professor of medicine at Ohio State University and director of the Division of Endocrinology and Metabolism in the Department of Medicine.

* * *

Dwight M. Palmer, M. D., Columbus, has been reappointed a member of the Committee on Rating of Mental and Physical Impairment of the AMA.

The AMA Committee develops practical guides to assist physicians in evaluating permanent impairment of body systems and organs.

* * *

Thomas E. Shaffer, M. D., Columbus, has been reappointed a member of the Committee on Medical Aspects of Sports of the AMA.

The AMA Committee advises athletic personnel on the various phases of the health supervision of sports, and disseminates information to interested physicians on the application of medical skills in the athletic setting.

* * *

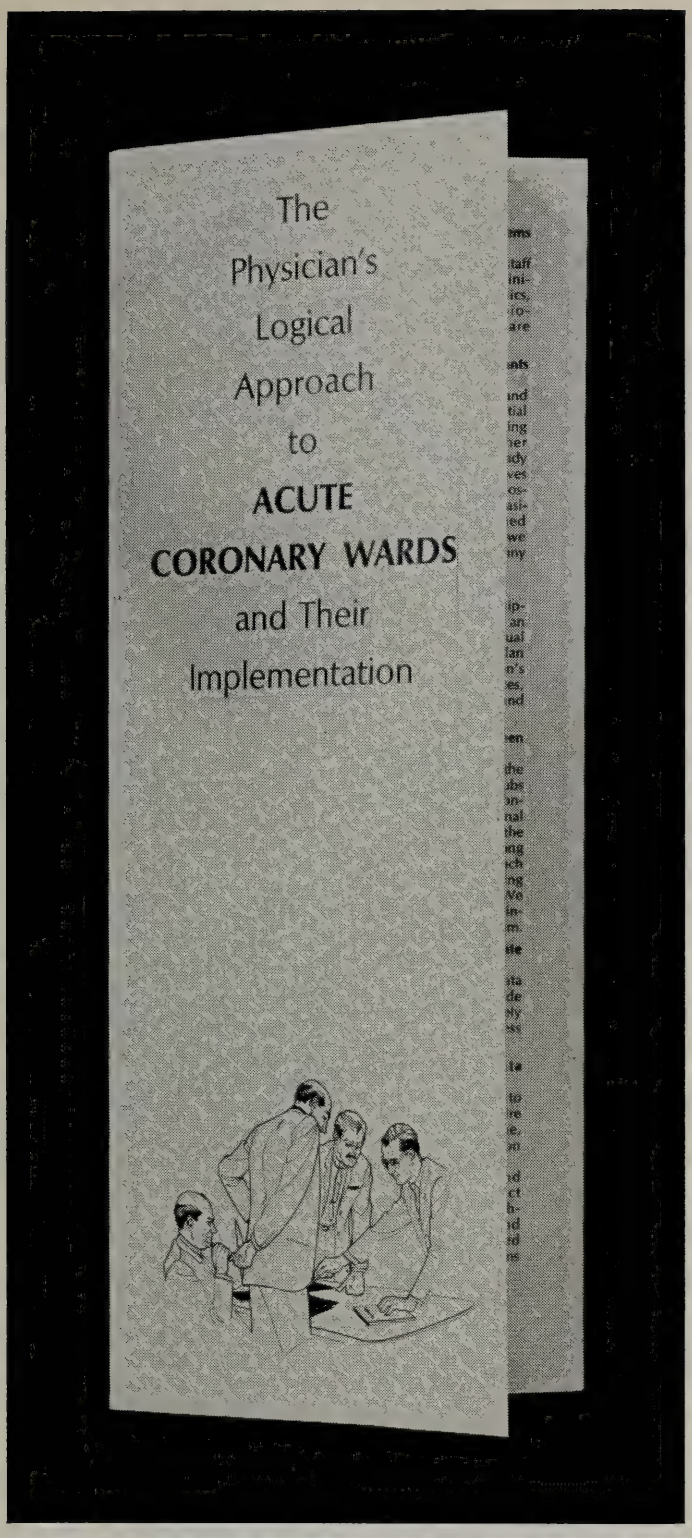
James V. Warren, M. D., Columbus, has been reappointed a member of the Committee on Rating of Mental and Physical Impairment of the AMA.

The AMA Committee develops practical guides to assist physicians in evaluating permanent impairment of body systems and organs.

Children's Hospital, Columbus Served 84 Ohio Counties

In the neighborhood of a hundred thousand children visited Children's Hospital of Columbus during 1965, according to the hospital's annual report issued recently.

They came from 84 counties in Ohio and from 18 other states. Here are the 1965 statistics at a glance: Admissions, 14,125; average daily census, 240; average length of stay, 6.2 days; emergency room visits, 34,072; outpatient visits, 50,840; patient days, 87,760; unpaid care, $359,000.



for
physicians
involved in
planning
and
implementing
intensive
care
and coronary
wards
for hospitals

Here's a concise,
non-technical guide you
can read in minutes and
profit from immediately.

Free copies available upon request.
Send coupon or write to:

(Data corporation)

Mr. B. A. Friedman, Manager, Information Systems
7500 Old Xenia Pike/Dayton, Ohio 45432 (426-3111)

Please send me a copy of "The Physician's Logical Approach to Acute Coronary Wards and Their Implementation."

Name:_____ Title_____

Hospital:_____

Address:_____

City_____ State_____ Zip_____

Obituaries

Ad Astra

Richard Stevens Bechk, M. D., Cleveland; Faculty of Medicine of the University of Budapest, 1930; aged 68; died April 13; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Bechk practiced for some 34 years in that city. Among affiliations, he was a member of the Rotary Club. Survivors include his widow, two daughters, two brothers and a sister.

Berton M. Hogle, M. D., Troy; University of Cincinnati College of Medicine, 1928; aged 66; died April 12; member of the Ohio State Medical Association and the American Fracture Association; Fellow of the American College of Surgeons. A physician and surgeon in the Troy area for many years, Dr. Hogle was active in a number of medical organization groups. He was treasurer of the Ohio State Surgical Association and a past president and former secretary-treasurer of the Ohio Chapter, American College of Surgeons. A veteran of World War I, during which he served in the Marine Corps, he was a member of the American Legion; also a member of the Elks Lodge and the Methodist Church. Surviving are his widow, a daughter, two sons, one of whom is Dr. Glen Hogle, of Santa Ana, Calif.; also a sister.

Roy F. Jolley, M. D., Richwood; Ohio State University College of Medicine, 1914; aged 73; died April 16; member of the Ohio State Medical Association and the American Medical Association. A native of the Richwood area, Dr. Jolley returned there to practice in 1953. He previously was in Akron where his specialty field was surgery. He was a veteran of World War I, a member of the American Legion, the Methodist Church, the Lions Club, and several Masonic bodies. Survivors include his widow, two sons, and two sisters.

Boyd G. King, M. D., Cleveland; University of Nebraska College of Medicine, 1933; aged 57; died April 10; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Internal Medicine. A practicing physician in Cleveland for more than 30 years, Dr. King was on the faculty of Western Reserve University School of Medicine. During World War II, he was a lieutenant colonel with the Fourth General Hospital unit. Survivors include his widow, two sons, his mother and a brother.

Gerald J. Krupp, M. D., Lorain; St. Louis University School of Medicine, 1931; aged 61; died April 20; member of the Ohio State Medical Association and the American Academy of General Practice. An earlier resident of Lorain, Dr. Krupp returned there to practice after taking his medical training. In addition to his professional affiliations, he was a member of the local Businessmen's Association, the Lions Club, Elks Lodge, the Catholic Church, Knights of Columbus, and Holy Name Society. Neil E. Krupp, M. D., of the Mayo Clinic, and Ralph J. Krupp, D. D. S., of Lorain, are among four surviving sons. Other survivors are his widow, and three daughters.

Carl William Lose, M. D., Flushing; University of Cincinnati College of Medicine, 1912; aged 79; died April 5; member of the Ohio State Medical Association, and the American Medical Association. Dr. Lose practiced for 52 years in the Belmont County community. Among affiliations, he was a member of the Methodist Church and several Masonic bodies. Surviving are his widow, four brothers and a sister.

James Albert Magoun, M. D., Toledo; University of Pennsylvania School of Medicine, 1916; aged 77; died April 26; member of the Ohio State Medical Association, the American Medical Association, American Urological Association; Fellow of the American College of Surgeons; diplomate of the American Board of Urology. A physician and surgeon in Toledo for more than 42 years, Dr. Magoun was one of the cofounders of the Toledo Clinic. He was a veteran of World War I, during which he served in the Navy Medical Corps. Among survivors are his widow, a son, and a daughter.

Norvil A. Martin, M. D., Santa Barbara, Calif.; Washington University School of Medicine, 1930; aged 61; died April 25; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Otolaryngology. A former practitioner in Gallipolis for many years, Dr. Martin was one of the founders of the Gallipolis Clinic. He retired in 1962 and moved to California. Affiliations included memberships in the Presbyterian Church and several Masonic bodies; also the Rotary Club. A veteran of World War II, he is survived by his widow and two daughters.

Harry Miller Robuck, M. D., Gomer; University of Louisville School of Medicine, 1921; aged 74; died April 13; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in the Allen County community, Dr. Robuck was active in Republican affairs and was former chairman of the county central



the mid-rift!

Our population's bursting at the seams.

It's eat. Eat. Eat.

And then diet. Diet. Diet.

With the latest No-calorie.
No carbohydrate. No-vitamin. No exercise.
400-hour Kamikaze Plan!

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committee. He was a member of the Baptist Church and several Masonic bodies. A niece survives.

Edward Carl Rosenow, M. D., Minneapolis, Minn.; Rush Medical College, 1902; aged 90; died March 7; member of the Ohio State Medical Association, the American Medical Association, American Society for Experimental Pathology, and the American Society of Clinical Pathologists. Formerly associated with Longview State Hospital in Cincinnati, Dr. Rosenow contributed a number of papers in his specialty field of bacteriology to *The Journal.* Before coming to Ohio, he was located in Rochester, Minn., with appointments at the Mayo Clinic and the University of Minnesota. Dr. Rosenow was making his home in Minneapolis after retiring some ten years ago.

John Frederick Sanker, M. D., Cincinnati; University of Cincinnati College of Medicine, 1941; aged 51; died April 5; member of the Ohio State Medical Association and the American Medical Association. A pediatrician in Cincinnati for some 20 years, Dr. Sanker, was on the faculty of the University of Cincinnati and was a past president of the Pediatrics Society and of the Medi-Club. During World War II he served as surgeon with the Coast Guard. Surviving are his widow, a son, three daughters, his parents, a brother and a sister.

Ernst Speyer, M. D., Miami, Florida; Medical Faculty of the Johann-Wolfgang Goethe University, 1924; aged 66; died March 20; member of the Ohio State Medical Association, the American Medical Association, and the American Psychoanalytic Association. Educated in Germany, Dr. Speyer practiced there and in Palestine before he came to this country. His practice in Sandusky extended over a period of 20 years prior to his retirement. Survivors include his widow, two daughters, and a son.

John Carl Stratton, M. D., Middletown; Cleveland-Pulte Medical College, 1908; aged 86; died May 2; member of the Ohio State Medical Association and the American Medical Association. A practitioner in Middletown since 1909, Dr. Stratton was active in numerous community and organization affairs. He was a member and former president of the local board of education for many years and was former city health commissioner. He was an elder in the Presbyterian Church, was a member of the Knights of Pythias and the Rotary Club. Dr. Frank M. Stratton, of Delaware, is a brother. Other survivors are his widow, a daughter and a son.

Ralph K. Updegraff, Jr., M. D., Bellefontaine; Western Reserve University School of Medicine, 1933; aged 56; died April 1; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Internal Medicine; diplomate of the American Board of Internal Medicine. Born in Cleveland, Dr. Updegraff's late father was a physician in that city. Dr. Updegraff, Jr., served in the Marine Corps during World War II, and began his practice in Bellefontaine in 1946. Among affiliations, he was a member of the American Legion, the Episcopal Church, and the Elks Lodge. Survivors include his daughter, a son, his mother and a sister.

John A. Welter, M. D., Roanoke, Va.; State University of Iowa College of Medicine, 1935; aged 55; died on or about April 16; former member of the Ohio State Medical Association. Dr. Welter practiced in Youngstown before he went into military service during World War II. Survivors include his widow, a daughter, two brothers, and a sister.

John F. Wilkinson, M. D., Bellaire; Ohio State University College of Medicine, 1923; aged 68; died April 5; member of the Ohio State Medical Association and the American Medical Association. A native of Bellaire, Dr. Wilkinson devoted all of his professional career to practice in the Belmont County area. He was a member of several Masonic bodies, the American Legion, and the Presbyterian Church. A sister survives.



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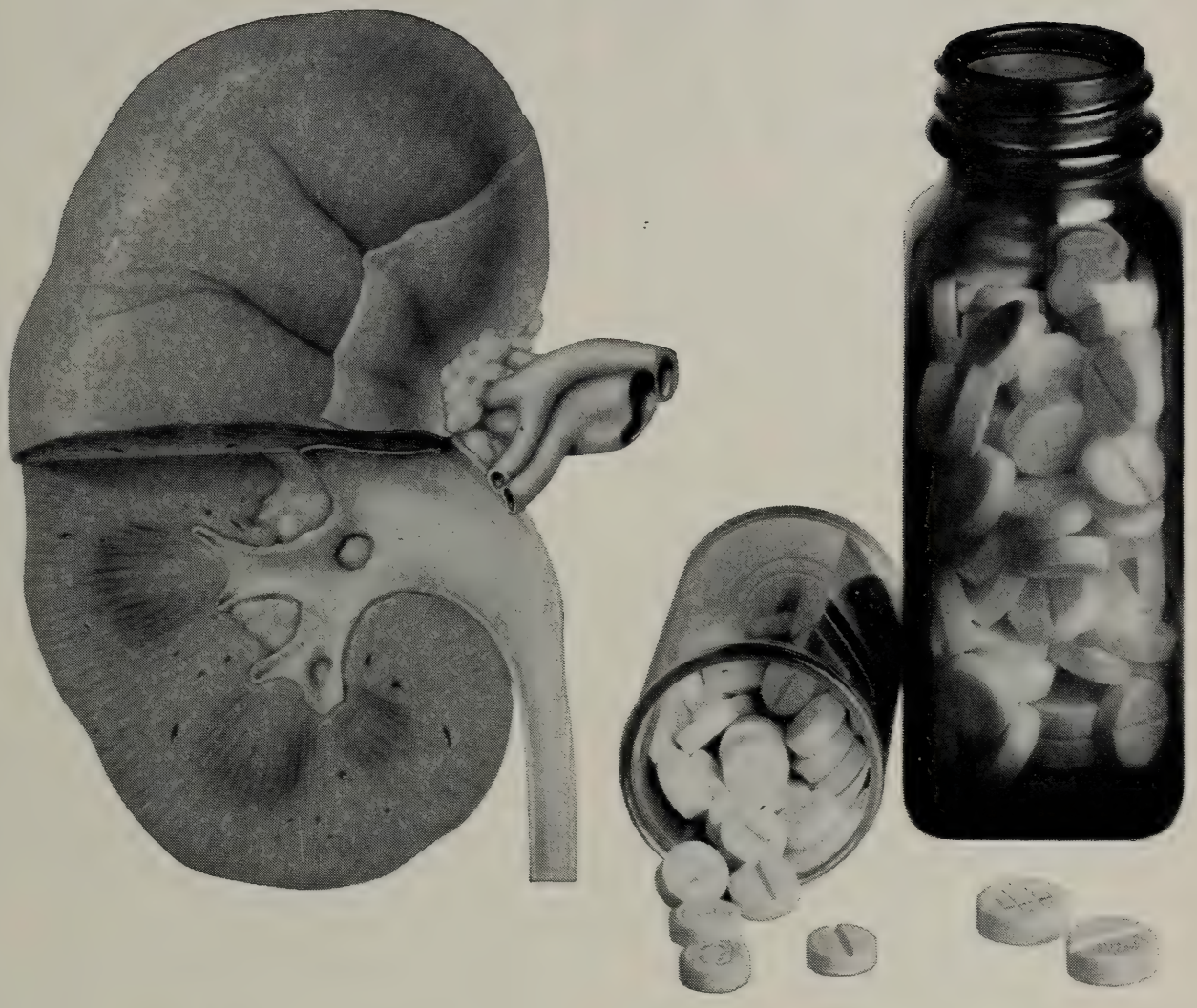
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Activities of County Societies ...

First District

HAMILTON

"Aspects of Autoimmunity" were discussed by Dr. William Dameshek, director of the Blood Research Laboratory at Tufts-New England Medical Center, at the April 19 meeting of the Academy of Medicine of Cincinnati.

Second District

GREENE

Two physicians presented features of the program during the April meeting of the Greene County Medical Society in Xenia. Dr. William H. Havener, professor of ophthalmology at Ohio State University School of Medicine, discussed eye injuries; and Dr. Arthur Klein, Dayton, spoke on the subject of rheumatism fever.

Third District

ALLEN

Dr. Robert W. Hopkins, associate professor of surgery, Western Reserve University School of Medicine, was speaker for the April meeting of the Academy of Medicine of Lima and Allen County, where he discussed treatment of shock.

HARDIN

Dr. Ivan Podobnikar, of Columbus, was guest speaker at the joint meeting of the Hardin County Medical Society and Auxiliary in San Antonio Hospital, Kenton. His topic, "An Ounce of Prevention," was an urge for early treatment of mental illness. He also showed the film, "Strangers in the Shadow."

Fourth District

DEFIANCE

Featured speaker for the April meeting of the Defiance County Medical Society was Dr. Richard Kraft, assistant professor of surgery at the University of Michigan School of Medicine. His topic was "Peripheral Vascular Disease."

LUCAS

The Specialty Section meeting of members of the Academy of Medicine of Toledo and Lucas County was held on May 19. Speaker was Dr. Curtis Lund, professor of obstetrics and gynecology at the University of Rochester (N. Y.) who discussed "Ion Metabolism and Anemia in Pregnancy."

The Postgraduate Lecture Series was given on May 12 and 13 at the Academy Building with Dr. Robert D. Johnson, University of Michigan, as guest speaker. Theme of the series was "Some Recent Advances in Medicine."

Fifth District

CUYAHOGA

The Academy of Medicine of Cleveland held its annual meeting with the Auxiliary on May 13, with dinner at the Mid-Day Club. Dr. William F. Boukalik, president, presided. The Woman's Auxiliary, with Mrs. Elden C. Weckesser, president, presented a skit entitled "Auxiliary Shows Her Medals, or Twenty-Five Sterling Years."

Dr. Charles L. Hudson, Cleveland, President-Elect of the AMA, was honored on this occasion by his home Academy.

The Cleveland Academy has announced its annual golf outing to be held at Shaker Heights Country Club on Monday, July 18.

Seventh District

BELMONT

The Belmont County Medical Society met with the Auxiliary at the Belmont Hills Country Club for dinner and a program. Guest speaker was Dr. Edmund Beshara, Canton, whose subject was "The Community Mental Health Program."

Eighth District

FAIRFIELD

The Fairfield County Medical Society has allocated $9,000 in treasury funds for the future expansion of Lancaster-Fairfield County Hospital. The funds represent excess donations by area citizens during the Sabin immunization program against polio conducted in the area about two years ago.

WASHINGTON

Dr. Jack Tetirick, of Columbus, discussed his experiences on a tour of service on the hospital ship *Hope* at the April meeting of the Washington County Medical Society in Marietta. Member of the Parkersburg Academy of Medicine were guests for the occasion, with the wives attending the meeting.

Eleventh District

ERIE

Members of the Huron and Ottawa County Medical Societies met with the Erie County Medical Society during April in Sandusky. Dr. William J. Feicks, described the program of the mental health unit at St. Joseph's Hospital in Lorain, and discussed mental health units in general. Such at unit at Good Samaritan Hospital in Sandusky is being developed.

LORAIN

Guest speaker at the regular meeting of Lorain County Medical Society on May 10 in Oberlin Inn,

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[1]Morrison, A. B. and Campbell, J. A., Journal of Pharmaceutical Sciences., 54, 1 (1965)

[2]Campagna, F. A., Cureton, G., Mirigian, R. A., and Nelson, E., ibid., 52, 605 (1963)

[3]Levy, G., and Hayes, B. A., New England Journal of Medicine, 262, 1053 (1960)

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was Ray C. Kepner, district manager of Lorain Office of the Social Security Administration. His topic, "Medicare and the Doctor," outlined the role of the physician and the Social Security Administration in the implementation of the new law, and the members were complimented on the instrumental effect the profession has had, and may expect to have in the future, in working towards improvement within the framework of Medicare.

Following a Question and Answer Period, J. A. Cicerrella, president, thanked Mr. Kepner for his informative program.

Dr. Lawrence C. Meredith, President-Elect of Ohio State Medical Association, extended an invitation to all members on behalf of Eleventh District Councilor William R. Schultz and himself, to visit the hospitality room and President-Elect's suite at the OSMA Annual Meeting in Cleveland, and reiterated Dr. Cicerrella's request that all who are able should represent the County Society at this meeting.

Voted unanimously into Associate Membership with the Society were Liselotte Marr, Alfonso Corzo-Moody, and Simon J. Isaac. Abdel Rahman Abla was voted an Active member, on transfer from Cleveland Academy of Medicine.

A Memorial Address to the late Dr. Gerald J. Krupp, of Lorain, was prepared and read by Dr. R. M. Arnold, and all present stood in silent tribute to their highly esteemed colleague.

Dr. A. Clair Siddall of Oberlin, chairman of the Cancer Committee, gave a brief report to the membership on the statistics of the current Uterine Cancer Detection Program among women on welfare, and those in the medically indigent group. In thanking all who have been participating in the program, he stressed the cooperation of the opt-patient clinic staff at St. Joseph Hospital in Lorain, and Elyria Memorial Hospital.

It was brought to the members' attention that Dr. James B. Patterson, of Lorain, was the first area physician to volunteer for duty with Project Viet Nam and has already left for service. It was also noted that Dr. Delbert D. Mason of Oberlin entered Military Service as of April 1.

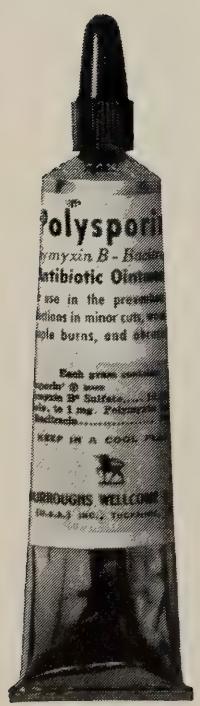
Dr. Cicerrella reminded those present of the joint meeting with the wives in September, when the Society will be host to Lorain County Medical Foundation's Board of Supervisors and members' wives, and the young students who will have been selected to receive grants for the school year 1966-1967.

RICHLAND

A discusisoin on the Medicare program was held when the Richland County Medical Society met on April 21 in Mansfield.

Guest speakers were Lee Forrest, assistant deputy administrator in the Chicago office of the Social Security Administration, and Hugh Hughes, Columbus, of the Nationwide Insurance Company, intermediary for the Medicare program in parts of Ohio and in West Virginia.

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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Publicity Committee

Chairman, 2442 Dorman Dr., Portsmouth 45662

THE PLACE is Chicago this year, and the Big event is the forty-third Annual Convention of the Woman's Auxiliary to the American Medical Association at the Drake Hotel, June 26 to 30, inclusive. Mrs. Richard A. Sutter, national president, sends a cordial invitation to all members, their guests, the wives of AMA delegates, alternates and international guests to participate in all social functions and to attend the general meetings.

Open forum discussions for state officers and constitutional amendments on Auxiliary structure will be features of this forty-third meeting. Registration opens at 11 A. M., Sunday, June 26, followed by a 6 - 8 P. M. reception honoring the Auxiliary president and president-elect (Mrs. Asher Yaguda).

The convention formally opens at 9 A. M. Monday, June 27. Featured speaker at that day's Guest Day luncheon will be Mr. Richard Cornuelle, executive vice-president, National Association of Manufacturers, and author of *Reclaiming the American Dream.* For Monday evening, there's a "Nite on the Town." The tour consists of dinner at the Ivanhoe Restaurant, banjo revue at the Red Garter, cocktails and browsing through Old Town and the Ice Revue at the Conrad Hilton Hotel.

Dr. James Z. Appel, AMA President, will speak at the Tuesday luncheon and Mrs. Sutter will present the Auxiliary's contribution to AMA-ERF. Dr. Raymond M. McKeown, foundation president, will present awards to state and county auxiliaries making the largest contributions in their membership categories. The new convention program scheduled for Tuesday afternoon — "Open Forum — is a two-way discussion between state presidents and presidents-elect, and national officers and chairmen. On Wednesday, June 29, Mrs. Yaguda will be installed as president.

There will also be an exciting five-day and two-evening program offered physicians' pre-teens (ages 6-12) and teens during the convention. The activities, handled by Gulliver's Trails, Inc., are under the auspices of the Woman's Auxiliary. What your reporter has presented here on the National Convention is, of course, nothing more than a bird's eye glimpse. All of it sounds truly exciting, interesting and informative. Set your sails for Chicago!

Around Ohio

The **Butler County** auxiliary heard a talk on "Medical Legal Responsibility under Medicare" at a recent meeting. Gaston Herd, administrator of Forst Hamilton Hospital, was the speaker. Invited to the luncheon meeting were members of the Butler County Bar Auxiliary. The **Clinton County** group honored its doctors recently with Doctors' Day Dinner given annually at the home of Dr. and Mrs. Arthur F. Lippert. Mrs. Lippert used a valentine motif. The tables were centered with flowers and hearts in milk glass vases, and the large table featured a valentine coach and red candles in hurricane lamps.

After a visit to George Mark's "Salt Box" in April, the **Columbiana** auxiliary had a luncheon meeting in the Hearth Room at Holiday Inn. Mrs. Wade Bacon, president, led a discussion on the Columbiana County Mental Health's proposed tax levy. Members voted unanimously to endorse the passage of this levy. The group also approved financial aid, through its health career fund, to an applicant from Salem to further her nursing career. The loan fund, repayable after graduation, is open to students in any of the paramedical careers.

The final meeting of the year was held in May and was the annual Rose Luncheon at East Liverpool Country Club when the new officers were installed. They were: Mrs. R. J. Bonstalli, president; Mrs. K. S. Ulicny, president-elect; Mrs. Stephen Sinclair, vice-president; Mrs. A. P. Falenstein, treasurer; and Mrs. Fred Banfield, secretary. Mrs. Janis Lauva served as chairman for the Rose Luncheon and installation.

Franklin County's traditional Guest Day featured a salad smorgasbord at the Covenant Presbyterian Church. Robert Titko, director of Planned Parenthood, spoke on "World Population Explosion." Diminutive Flemish arrangemnts of violets decorated the tables at the annual Spring bridge luncheon given by the **Lucas County** Auxiliary in April. Proceeds from the afternoon in the amount of $300 were given to AMA-ERF. Mrs. John R. Van der Veer was chairman of the day's festivities assisted by Mrs. Harvey Muehlenbeck, cochairman; Mrs. Edward Claxton, Mrs. Paul J. Ditmyer, Jr., Mrs. Everett Kasher and Mrs. Harold Wachenheim. Mrs. Richard Schafer is the new Lucas County president. The group's



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Senior Citizens' Tea was held on May 6 at the Academy. The Community Service Committee acted as hostesses, with Mrs. Jose Guerra as chairman. The International Health Committee reports a very successful year. About 30 large cartons of drugs were delivered to Detroit by Mrs. Marvin Green, Mrs. Max Schnitker and Mrs. Irvin McConnell.

A Woman Honored

The **Stark County** Auxiliary is bursting with pride over an honor recently given one of its outstanding members — Mrs. Mark G. Herbst. Mrs. Herbst was named Woman of the Year recently by the Junior League of Canton — a tribute paid annually for hours devoted to volunteer service. In presenting the award, Mrs. Robert E. Levitt, president of the League commented "Mrs. Herbst has a deep feeling of responsibility to her community and to her fellow man. She does not merely lend her name to community boards, but gives tireless hours of dedicated work."

Virginia Herbst is a very active Auxiliary member and a past president of the Stark County group. Just last year, she received an award from the Urban League for "her outstanding work to the underprivileged and senior citizens." Selection of Woman of the Year is made by a panel of judges from nominations submitted by civic, welfare, health and educational groups in the community. Every time a doctor's wife is so honored, it points up the significance and importance of our place in the community — and our individual responsibility to our individual communities. You serve as a shining example, Virginia Herbst. Our congratulations . . .

The annual Public Scholarship Dance sponsored a few months ago by the Stark group made possible further proceeds to assist young people who need financial assistance for training in paramedical fields. This year, scholarship money is being lent to student nurses — two at Aultman Hospital, five at Mercy Hospital and one at St. Thomas Hospital in Akron.

For the fourth consecutive year, this same energetic group of women are packaging drugs to be sent to World Medical Relief. The current project has been carried out at the home of Dr. and Mrs. Jack Hendershot.

May Day Breakfast

Scioto County auxiliary held its traditional May Day Breakfast and installation of new officers on May 11, as it has for many years, at the home of Mrs. Herbert M. Keil. Mrs. Alden Oakes, retiring president, conducted the business session and called upon her chairmen to give their annual reports. The installation ceremony was given by Mrs. Francis Kulcsar, ninth district director. New Scioto County officers include: Mrs. Harlan Williams, president; Mrs. Clyde Hurst, president-elect; Mrs. George Martin, vice-president; Mrs. B. U. Howland, treasurer; Mrs. Robert E. Martin, secretary; Mrs. Carl Braunlin, historian; Mrs. Alden Oakes and Mrs. Jerome Rini elected members to the Board.

Trumbull County sent out an effective News Letter to its membership in April. Edited by Geneva Kohn, it highlighted events for April and May. This News Letter idea is such a good way of "keeping in touch" and I'm sure the Trumbull gals won't mind it a bit if the rest of you copy that idea! The April meeting of the group was a brunch at the home of Mrs. Donald Miller and highlighted election of officers, a talk on Civil Defense and "cards and chatter." The auxiliary was invited by the Corydon-Palmer Dental Auxiliary to be guests at a luncheon given by them for foreign exchange students. The program featured "Let's Build World Peace." The annual Gardenia Ball was held on April 29 at the Trumbull Country Club.

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The OHIO STATE MEDICAL Journal

VOL. 62 JULY, 1966 NO. 7

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Ohioans Inducted into Fellowship by American College of Physicians

A number of Ohio physicians were among those recently honored at the 47th Annual Session of the American College of Physicians (ACP). They were inducted into Fellowship in the medical specialty society which represents specialists in internal medicine and related fields.

Among the Fellows inducted were:

Drs. Henry Beekley, Jerome R. Berman, Richard C. Bozian, John L. Friedman, E. Gordon Margolin, Louis M. Rosenberg, Stuart A. Safdi, all of Cincinnati; Drs. Bernard Chojnacki, Harriet E. Gillette, R. Thomas Holzbach, O. Peter Schumacher, Eugene Winkelman, all of Cleveland; Drs. D. Bruce Sodee and Jim R. Young, both of Cleveland Heights;

Drs. Richard D. Carr, William A. Millhon, Robert J. Murphy, and Robert L. Perkins, all of Columbus; Dr. Raymond H. Murray, Dayton; Dr. Edward O. Hahn, Fairview Park; Dr. Robert A. Hahn and Dr. Lee Sataline, both of Lakewood; Dr. John L. Bauer, of Middletown; Dr. R. E. Roy, of Ravenna; Dr. Brian K. Bradford, Toledo; Dr. Viola Startzman, Wooster, and Dr. Leonard Caccomo, Youngstown.

Dr. Louis J. Goorey, Worthington, was elected president of the Ohio Junior Chamber of Commerce at the recent Jaycees annual meeting in Columbus.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during May. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

Butler
William T. Repasky, Middletown
William T. Scott, Middletown
Stephane Zelling, Middletown

Cuyahoga
Berly E. Bridges, Jr., Cleveland
Cathel A. MacLeod, Cleveland
Earl F. Shields, Jr., Cleveland
Kathleen J. Simak, Cleveland
William K. Sterin, Cleveland

Geauga
Neil V. Johnston, Chardon

Hamilton
Thomas J. Ball, Jr., Cincinnati
Robert D. Green, Cincinnati
Donald H. Jansen, Cincinnati

Hamilton (Continued)
E. Bruno Magliocco, Cincinnati
Victor M. Napoli, Cincinnati
Majid A. Qureshi, Cincinnati
Thomas A. Saladin, Cincinnati
William L. Santen, Cincinnati
Ieva Veveris, Cincinnati
Edward W. Walters, Cincinnati

Lorain
Liselotte A. Marr, Avon

Lucas
Fernando Crotte, Toledo
Baltazar J. Reyes, Toledo

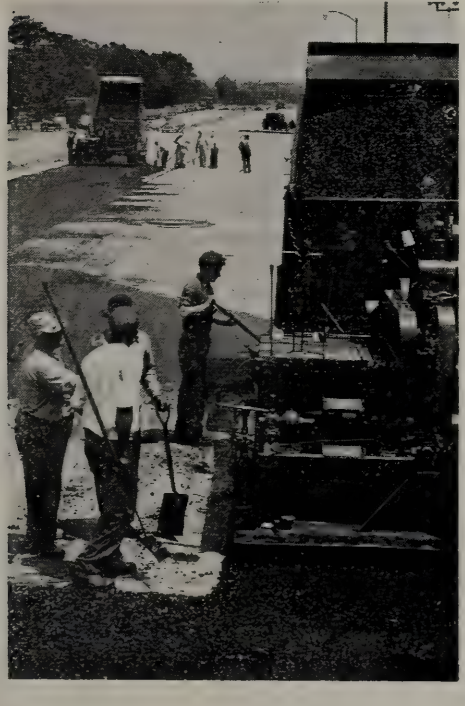
Ottawa
Luis Mantalvo, Port Clinton

Summit
Roger E. Hakim, Barberton

Dr. Samuel Saslaw, professor of medicine and microbiology at Ohio State University College of Medicine, received an honorary Doctor of Science degree during commencement ceremonies at Transylvania College, Lexington, Ky.

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"THE MOST EFFECTIVE SUNSCREEN"[1] OR WINDSCREEN

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RED PETROLATUM



RVP-Elder, called "the most effective sunscreen," is also an ideal windscreen.

Constant occupational exposure to sun and wind often causes major discomfort in producing irritating sunburned and windburned skin . . . commonly found in street workers, construction workers, and telephone linemen, to mention a few.

There's reassuring protection and skin comfort for those outdoor workers who use RVP-Elder. Swimmers, golfers and others engaged in outdoor activities can have the same skin protection.

A razor-thin layer of only 10 microns adheres tenaciously to the skin for hours, yet washes off easily with soap and water. Virtually invisible, RVP-Elder is odorless, non-staining, and perspiration and water resistant, even while swimming. No sensitivity has been encountered.

Supplied in 2 oz. and 16 oz.

Write for clinical trial package and absorption spectrum –

References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.

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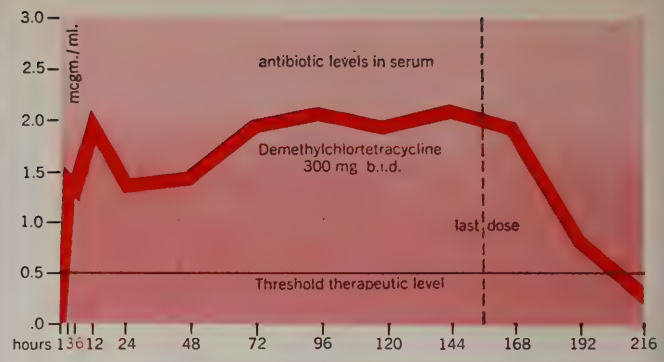
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From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.;
Amer. J. Med. Sci. 243:296 (Mar.) 1962



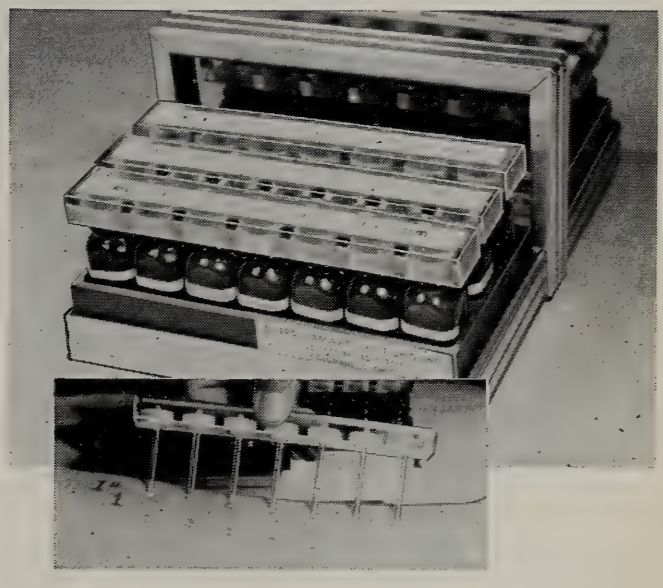
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This easy three-step allergy test kit contains 42 Allergens, clinically selected. The new testing technique allows you or your nurse to apply 7 different drops of potent allergens to the skin at one time. It's economical, fast . . . allowing you to manage allergy diagnosis with minimum time and cost.



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The physician's prescription of therapeutic antigens for the individual patient are carefully compounded in our laboratories by following the clinical diagnostic indications of skin test and history reports submitted.

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When clinical diagnosis indicates a clear seasonal pattern of sensitivity you may desire a combination of the most prevalent antigens occurring in that season. You may choose from these stock treatment sets; Ragweed Mix, Grass Mix, Tree Mix, Mixed Mold Treatment, Dust Treatment, Animal Dander (dog, cat or horse), Stinging Insect Mix.

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Allergy Laboratories of Ohio, Inc. has devised a new package to speed your prescription and reduce space requirements. The four vials are packed in a convenient window-clear plastic box with patient's name, and prescription numbers, face up. The bulky corrugated mailer box is thrown away after you've received your prescription.

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AMA Takes Responsibility For Project Vietnam

The American Medical Association is taking complete responsibility for Project Vietnam, the program under which American physicians volunteer to provide medical care to South Vietnamese civilians. Under AMA auspices the program will be known as AMA Volunteers for Vietnam.

The AMA has signed a contract with the State Department's Agency for International Development (USAID), assuming complete responsibility for recruitment and the administration of the program.

USAID has asked the AMA to become more strongly involved in the program. The AMA had previously helped recruit physicians but administration was handled for USAID by the People-to-People Foundation, Inc.

Under the program, U. S. physicians volunteer to work in South Vietnamese civilian hospitals on a short-term basis, usually 60 days.

Dr. Winslow J. Bashe, Jr., associate professor of preventive medicine at the University of Cincinnati, has been granted a fellowship by the Pan-American Health Organization for a three-months tour of European facilities where he will observe methods of preventive medicine and epidemiology.

Director Is Named for AMA Health Care Services

Roy F. Perkins, M.D., of Alhambra, California, has been named director of the American Medical Association's newly established Department of Health Care Services.

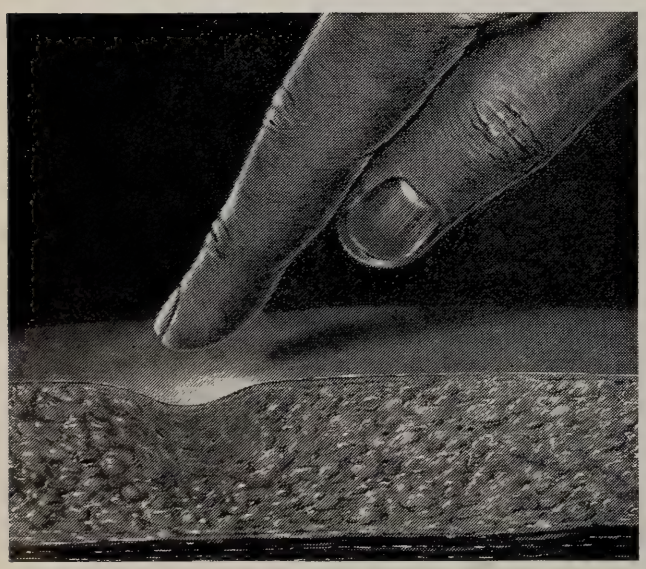
The Department of Health Care Services is one of six departments of the AMA Division of Socio-Economic Activities. The department will be concerned with community health services, voluntary health agencies, aging, maternal and child care, group practice, insurance and prepayment, patterns for the organization and delivery of medical care, manpower, and the business side of medical practice.

Dr. Edwin R. Westbrook, Warren, was named chairman of the Trumbull County Hope Chest in the Multiple Sclerosis Society drive. He is OSMA Councilor for the Sixth District.

Dr. Arthur E. Rappoport, Youngstown, discussed modern improved methods of laboratory procedures before a meeting of the New York State Association of Public Health Laboratories. Dr. Rappoport is consultant to the Advance Systems Development Division of IBM.

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(BENZTHIAZIDE)



NEW FROM TUTAG for prompt, comfortable diuretic action with a balanced excretion of sodium chloride and a lower potassium loss under normal dosage and diet regimen

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease, advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

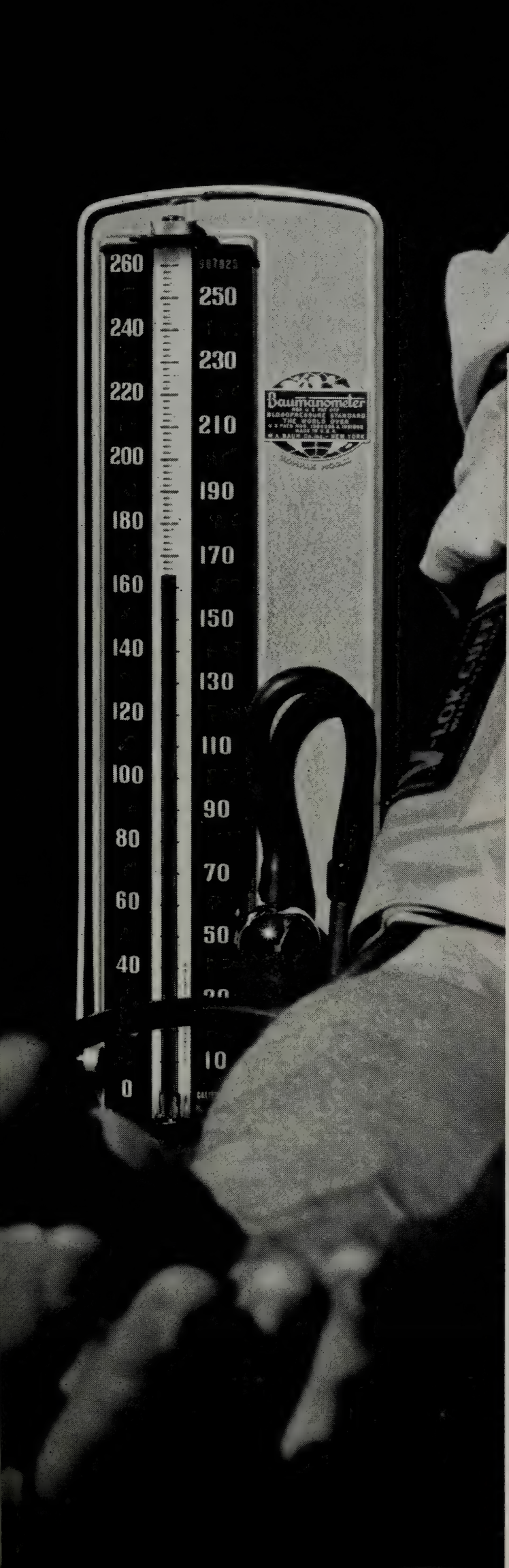
CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

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when readings indicate hypertension

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to reduce blood pressure

In the management of your hypertensive patients, Naturetin is good therapy to start with, good therapy to stay with.

In mild hypertension, Naturetin lowers blood pressure gradually toward normotensive levels. In long-term therapy, Naturetin may keep blood pressure low—for months, sometimes years. When used in combination with other antihypertensive agents, blood pressure often falls further—and lower doses of both drugs are usually possible.

Clinical trials have proven Naturetin effective—without serious side effects.[1,2] And, when used to treat patients with cardiac edema and hypertension, "in no instance did the concentration of serum potassium fall below 3.1 mEq. per liter."[3] (Normal range for serum potassium: 3.5-5.0 mEq./liter).[4]

When readings indicate hypertension, start with Naturetin, stay with Naturetin.

Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available—Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: 1. Telfeyan, S. A.: Clin. Med. *70*:1668, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. *11*:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. *12*:161, 1964. 4. Castleman, B., ed.: New England J. Med. *268*:1462, 1963.

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Environmental Health Project Authorized for Cincinnati

With a $6.5 million United States Public Health Service grant, the University of Cincinnati will be in the forefront as a leading center for the study of environmental health. The grant will launch and cover a seven-year program for a University Center for study of the Human Environment.

The proposed center will be university-wide, representing disciplines in the Graduate School, Medical Center, College of Engineering, and McMicken College of Arts and Sciences.

City and Federal health agencies, including the USPHS Robert A. Taft Sanitary Engineering Center in Cincinnati, will co-operate in the university center's activities.

Dr. Edward P. Radford, professor of environmental health and physiology, is chairman of the university's Environmental Health Council. This is the administrative group responsible for operating the center.

Immediate purposes of the center include: Drawing together and co-ordinating research and teaching activities in environmental health already in existence in the university; planning for expansion in new areas of environmental health or strengthening existing campus resources as new programs are developed; and developing better research and training programs in association with the USPHS, Robert A Taft Sanitary Engineering Center, Division of Occupational Health, Health Department of the City of Cincinnati, and Ohio River Valley Water Sanitation Commission.

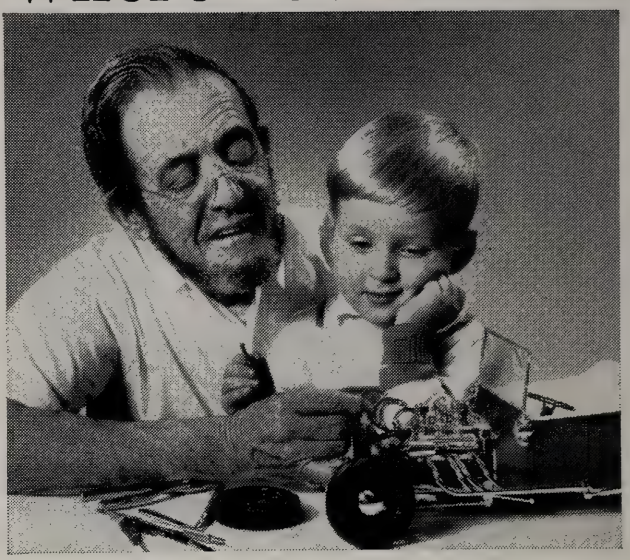
Areas at the university already conducting established programs relating to environmental health include the department of environmental health and its Kettering Laboratory, the Division of Sanitary Engineering in the College of Engineering's Department of Civil Engineering, and the Graduate School's Division of Community Planning.

Among a wide range of research activities in the fields of environmental health already under way on the Cincinnati campus are: Experimental toxicology and radiation biology, effect of environmental factors on human populations, analysis of the distribution of potential hazards in the environment, engineering for control of environmental pollution, planning for health evaluation and for control of health hazards in urban environments.

Dr. Thomas E. Shaffer, professor of pediatrics at Ohio State University College of Medicine, spoke on the topic "Today's Teenager," at a meeting sponsored by the OSU Hillel Foundation.

Dr. Herman K. Hellerstein, Cleveland, discussed "Prevention of Coronary Heart Disease — A Challenge" at a program in Findlay sponsored by the Hancock County Heart Association.

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Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy. LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. LEPTINOL® may be prescribed for patients with mild hypertension or other organic diseases.

Each LEPTINOL® bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE one or two tablets, 3 times daily.

Side Effects: overdosage may produce tremor, convulsions or respiratory paralysis.

Caution should be taken when treating patients with a low convulsive threshold. Patients should be warned not to exceed recommended dose which offers maximum effectiveness.

Write for detailed literature and starter LEPTINOL® doses.

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Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

* * *

Probably very few physicians have filed patent applications (1,600 are filled every week). And yet few other groups have benefited more as a direct result of the patent system. In 1965, for example, the pharmaceutical industry spent almost $1 million a day on research and development — seeking new and better products for the physician's armamentarium. What would happen, possibly in days, if the patent system fell by the wayside? Would a drug firm spend hundreds of thousands or millions of dollars on a product if, having crossed the threshold of success, it knew its competitors could gobble up the profits? — Editorial in *GP* (32:5), November 1965.

* * *

Many economists are convinced that the American system of patents and trademarks and brand names has been a vital factor in the great progress of the United States and its leadership in establishing a standard of living superior to that anywhere else in the world. The factors involved include not only this system but also the right to advertise, the right to disseminate information, and the right to legitimate pride in distributing as widely as possible the benefits of new inventions and discoveries. How much time must pass before the ultimate effects of the new (drug) legislation become apparent is difficult to predict. The effects are only beginning to be felt. Perhaps the time is near when the legislators will have to take a second look. — Morris Fishbein, M. D., in *Postgraduate Medicine,* (39:205-206), February 1966.

* * *

When a prescription contains a generic name, it is still incumbent on the pharmacist to dispense a drug he knows to be of the highest quality. Shall we give our patients the cheapest? Is it through no accident that cheap has come to mean inferior as well as inexpensive? When a reputable and well known house puts its name on a product, it has added something to it, and what may be its most important element. If we could be sure that our patients could get the same medication and save money while doing it, other arguments might not carry the day. But if there is a difference, then it is well worth it. — Frank Cole, M. D., in *Nebraska State Medical Journal,* (50:507), October, 1965.

* * *

Mussolini abolished drugs from the Italian patent system in 1939. Now more than 750 Italian laboratories devote their entire production to pharmaceuticals developed by foreign drug companies or by other Italian firms. These labs generally employ fewer than 10 persons and rarely more than 50.

Bamadex® Sequels®

Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

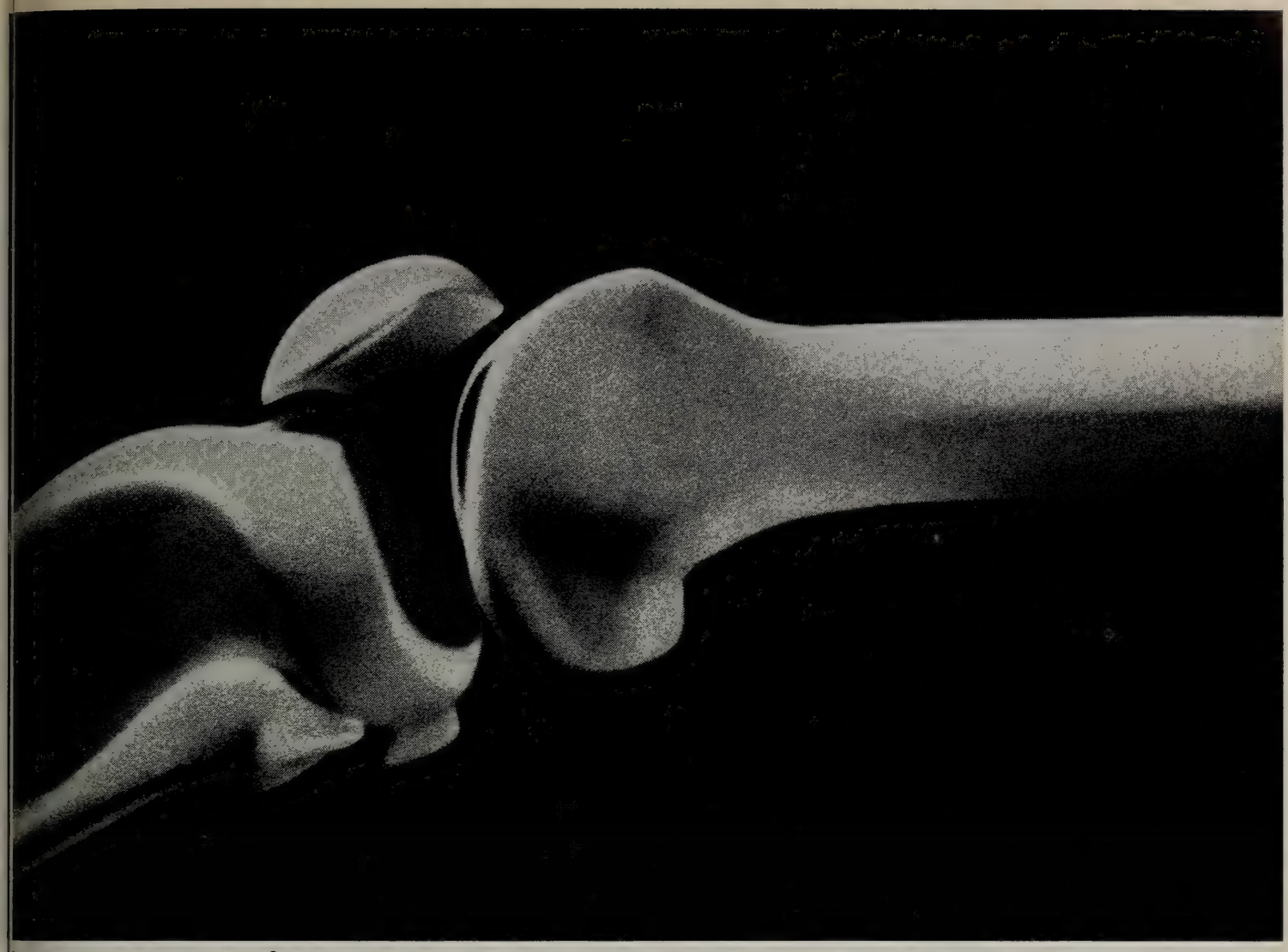
Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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enylbutazone	100 mg.
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gnesium trisilicate	150 mg.
natropine thylbromide	1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

e trial period need not exceed 1 week. In ntrast, the recommended trial period for lomethacin is *at least 1 month.*

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arge number of investigators have re-rted major improvement in about 75% of ses. Some patients have gone into remis-n. Relief of stiffness and pain may be fol-ved quickly by improved function and res-ution of other signs of inflammation. And tazolidin alka is well tolerated, especially ce it contains antacids and an antispas-dic to minimize gastric upset.

ntraindications
ema, danger of cardiac decompensation; tory or symptoms of peptic ulcer; renal, patic or cardiac damage; history of drug ergy; history of blood dyscrasia. The drug ould not be given when the patient is se-e, or when other potent drugs are given ncurrently. Large doses are contraindi-ted in patients with glaucoma.

ecautions
tain a detailed history and a complete ysical and laboratory examination, includ-ing a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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The Historian's Notebook

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M.D., M.P.H.*

PART I

Dr. Clark W. Davis: 1900-1904

DR. CLARK W. DAVIS, who took over the reins from Dr. W. A. R. Kenney on April 10, 1900, gave the population of the city that year as 325,902. The deaths numbered 5,412 giving a mortality of 16.60 per 1,000.

"I find that the City of Cincinnati is to be congratulated on entering the 20th century with the lowest mortality in her career . . ." he added.

As to the causes of mortality, the Health Department had just adopted the Bertillon system — the international nomenclature as adopted by the Eighth International Congress of Hygiene and Demography, held at Paris in 1900. But like his predecessors, Dr. Davis had a problem with reporting. "I cannot urge too strongly upon the attention of physicians and midwives the vital importance of promptly reporting to this office all births . . ." he wrote.

The Dunham Hospital

There is one disease that in cities causes a greater mortality than any and all other infectious or contagious diseases combined, and more than any epidemic that has prevailed for a decade, and also about which people are least anxious owing to their lack of knowledge. I refer to consumption in all of its forms . . .

Congratulating the city on being "wide awake to the inroads of the disease," Dr. Davis noted that Cincinnati had established "the first municipal hospital for the exclusive treatment of the disease — The Dunham Hospital." The average daily number of patients treated, he gave as follows:

Year	Average	Year	Average
1897	20	1900	45
1898	30	1901	53
1899	38	1902	57

Diphtheria

Dr. Davis established a system of mailing in tubes whereby each culture is sent to the Department through the mail by the attending physicians . . . We are particularly qualified to handle these cultures . . .Also, antitoxin is furnished the poor of our city free of charge. This, however, is done under the general supervision of our assistant health officers — the district physicians . . .

Venereal Disease and Prostitution

"On the first of October, 1900, this department began the medical inspection of the prostitutes of the city. The result of such inspection has been phenomenal . . ." In this connection, Dr. Davis praised also Judge Lueders of the Police Court who encouraged "all evil-doers to lead better lives. He has given many of these fallen women an opportunity to reform by sending them to the homes of their parents and relatives instead of sending them to the Workhouse . . ." But he urged that in order to make "this system of inspection complete the city must have a venereal clinic or hospital . . ."

Other Problems

Dr. Davis urged the erection of an isolation hospital to take care of the other serious infectious diseases such as diphtheria and scarlet fever. He commended the "fine work" of the laboratory which has "never had better facilities for expert work than at this time." He deplored the fact that

chemicals are being resorted to by a class of milkmen who find it cheaper to use these adulterants and poisons for the preservation of milk than to give the proper time and attention requisite for abolute cleanliness of milkbuckets and milk cans . . .

He was also concerned about the water supply which "unfortunately is not all that could be desired . . ." But the new water works "now in course of construction" would be a major step in improving the supply. He urged that school buildings meantime, be supplied with filters.

On school health, he noted that "among 47,000 school children there is a large percentage from homes infected with disease . . ." He urged "therefore, the thorough weekly inspection of schools and school children."

Among other items, he was concerned with public dumps, tenement housing, public convenience sta-

(Continued on page 657)

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.
Submitted March 16, 1966.

tions, accurate recording of vital statistics and the inspection of meat. The staff numbered 82 including the district physicians, the various inspectors, and the clerks. But there were still no nurses in the Department.

Dr. Samuel E. Allen: 1905-1906

One of Dr. Allen's first acts was to establish a card index system so that each birth could be recorded and duly indexed daily. The enactment of child labor laws had increased the importance of this branch of the Bureau of Vital Statistics. Employees were prohibited, under the law, from employing children under 14 years of age. As well as verification as to age, a certificate of schooling was also necessary, signed by the superintendent of public schools, as a condition of employment.

In regard to school inspections, Dr. Allen wrote in his annual report (1906) that

> appeals for many years for the establishment of a school inspection system have at last borne fruit. Such a system went into force on January 1, 1907 . . . The physician must put himself in communication with the principal in each school in his district every day. If his services are required, he shall visit the school and examine the pupils referred to him. All pupils who return to school after an absence of four consecutive days shall also be examined . . .

On accidents in the streets, he noted that there were 22 such accidents in 1906, with a total of 80 persons injured or killed. There were 13 deaths. Illustrative of the developing street accident problem, he noted that "Dr. J. S. Atkin's auto caught between two cars on Vine Street Hill exploded, 16 being hurt, two very seriously . . ."

At a time when only about 3 per cent of the population attained an age in excess of 65 years, he noted that "the greatest age attained by a decendent in 1906 was 96 years . . . a widower born in Germany . . ."

Dr. Mark A. Brown: 1907-1909

Dr. Brown, now in charge of the Department's school health program noted that the following cases were referred for treatment through the system:

Defective eyesight	3184
Diseases of eyes	502
Defective hearing	272
Otitis media	190
Hypertrophied tonsils	1818
Adenoids	486
Tonsilities	459

As to the importance of the milk supply, he wrote:

> The milk supply is rapidly assuming the most important place in health department work. With the passage of new and more stringent laws, the work of the milk inspector has become more and more arduous . . . It is therefore recommended that the corps of assistants be increased . . .

Like his predecessors, Dr. Brown had a problem in obtaining complete reporting from the physicians. He expected a large increase in the birth returns, now that by the law establishing a Bureau of Vital Statistics "the prompt and permanent registration of all births and deaths within the State of Ohio" was required. A penalty of $50 for failure to report could be extracted under this law.

Vitally concerned with tuberculosis control, Dr. Brown noted that

> the tuberculosis dispensary has continued its career of usefulness . . .177 patients applying for relief . . . Probably its most important work is in the prevention of infection among those, who by ties of relationship, are compelled to be in more or less close contact with the tuberculous. During the past year the reporting of consumptive cases by physicians has steadily improved, but it has not yet reached as high a standard as it should . . .

Some 6000 specimens were examined in the public health laboratory, an increase of 11 per cent over the previous year (1906). These included 382 Widals tests for typhoid fever, of which a number of 131 were positive. During 1907 there were 1,252 cases of typhoid actually reported.

In 1909 the roster of the Department indicates a total of staff of 78 and three of that number were school nurses. After this we find gradually more and more nurses added.

The improved state of the milk was due not only to the work of the Department, but the interest of the Milk Commission of the Academy of Medicine. A system of education was tried out by the milk and dairy inspectors. This was expected to show "a material increase on the number of tuberculin tested herds."

The death dealers from among the infectious diseases in 1909 were:

	Deaths	Cases
Tuberculosis	859	1,058
Typhoid fever	46	1,252
Diphtheria	38	426
Scarlet fever	14	388
Measles	2	400
Whooping cough	21	136
Smallpox	1	253
Chickenpox	0	307
Cerebrospinal fever	11	15
Mumps	0	16
Erysipelas	32	91

Dr. J. H. Landis: 1909-1915

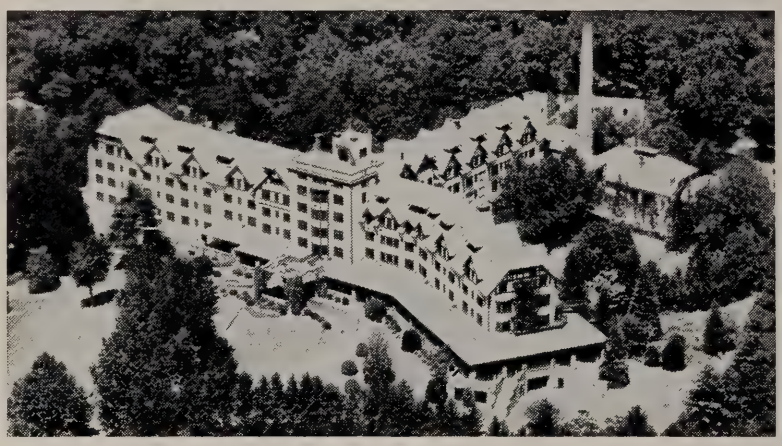
Dr. Landis took over the Department during 1909 with a staff of 89 inspectors, physicians, nurses, laboratory workers and clerks. There were now four public health nurses — one in anti-tuberculosis work, the other three in the Bureau of School Hygiene. The two special "sanitarians" in the Bureau of Infectious and Contagious Diseases presumably were engaged largely in "fumigation."

In these several reports, school health and milk inspection are given pride of place as the major activities in the Department. The "educational work" with the dairymen was beginning to pay off. Milk houses were being built, and sanitary milking pails "of the closed top" variety were beginning to become standard.

(To Be Continued in August Issue)

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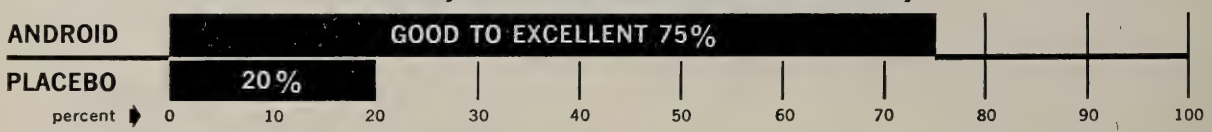
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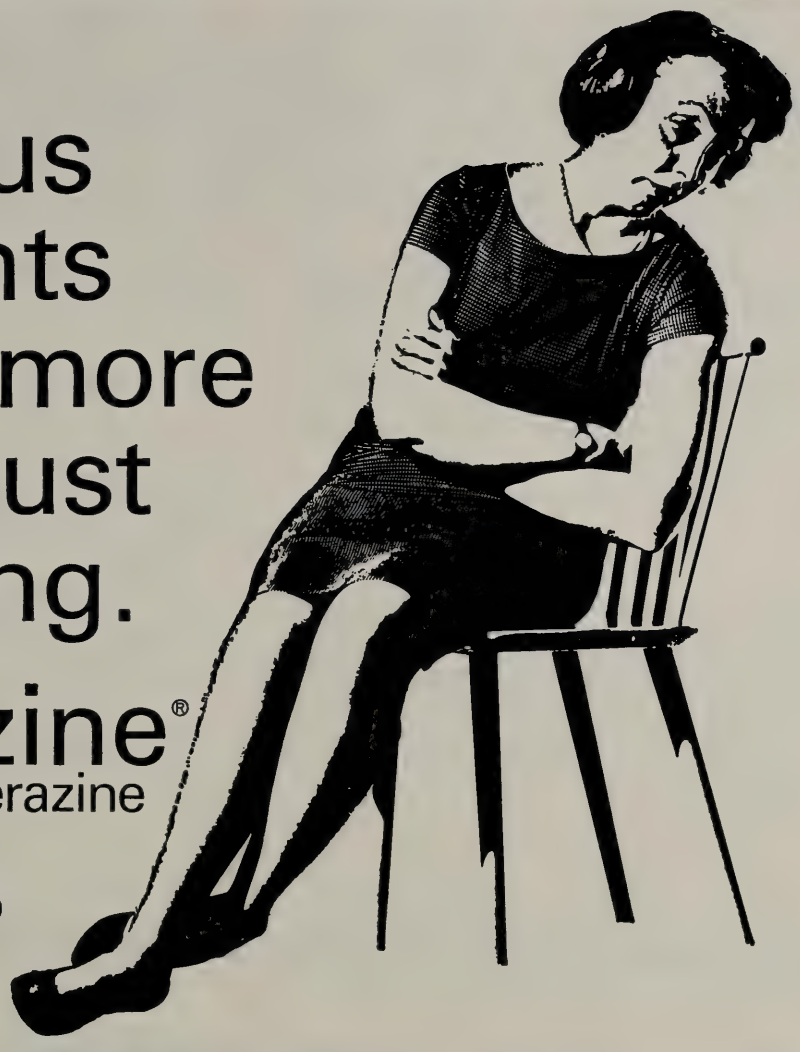
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Army Medical Department Issues Edition in History Series

The Medical Department: Medical Service in the Mediterranean and Minor Theaters; U. S. Army in World War II, the Technical Services; by Charles M. Wiltse, Ph. D., Litt. D., chief historian, U. S. Army Medical Service. (Catalog No. 64-60004, $5.00 from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.) The volume opens with a graphic description of the field medical service in action, then proceeds to an account of medical activities at the Atlantic bases from Greenland to Brazil, and in Central Africa and the Middle East — all areas in which the establishment of supply routes and a defensive perimeter preceded and supported combat operations against the European Axis. The remaining chapters are devoted to combat medicine, including one on Anzio, another on the invasion of southern France, etc.

Dr. Delbert A. Russell, Lorain, was elected president of the Eastern States Radiological Society at the group's annual meeting in Southern Pines, N. C. He is a past president of the Cleveland Radiological Society, and the Ohio State Radiological Society, and is now counselor for Northern Ohio to the American College of Radiology.

1966 Edition of New Drug Text Is Available from AMA

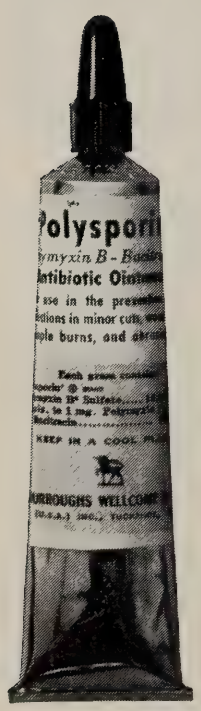
New Drugs Evaluated by the AMA Council on Drugs, 1966 Edition ($4.00, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610; $3.00 to medical students, interns and residents). New Drugs has been planned to meet the specific needs of the practicing physician for a source of up-to-date, authoritative, and unbiased information on more recently introduced drugs. This second annual edition has been enlarged and improved by the addition of five new chapters, monographs on over 30 recently introduced drugs, etc.

OSU Alumni Honored

Four physicians were honored at the recent reunion of the Medical Alumni Association of Ohio State University College of Medicine. Receiving alumni achievement awards were Dr. Edwin H. Artman, Chillicothe practitioner, and Past President of the Ohio State Medical Association; Dr. Samuel Saslaw, Columbus, professor at OSU, recognized for his research in infectious diseases; Dr. Emmerich von Haam, professor and chairman of the OSU Department of Pathology; and Dr. E. Richard King, chairman of the Department of Radiology, University of Virginia.

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Scientific Section

VOL. 62 JULY, 1966 NO. 7

Sound Perception

Its Theoretical History and Present Status*

JAMES T. McMAHON, M. D.

TWO vast areas of knowledge are the physics of sound and the psychology of hearing. Between these two is an abyss which the theory of hearing occupies only partially. The question as to how physical phenomena are converted into psychological experience leads one down a difficult and tortuous path. It demands a multidisciplinary approach, with physics, anatomy and physiology, psychology, and philosophy each having a prominent place.

From Philosophy to Biophysics

Greek epistemologists, in their search for the sources and validity of knowledge, were probably among the first to survey this unsettled ground. Primitive thinking began by equating what was sensed to the outside world. This might be called the principle of resemblances. It took centuries of reflection for the development of the idea that perception was analogous to the stimulating physical event, but no more than that. And indeed, this may be extended to include all knowledge, from a solipsistic standpoint. Truth then, and its human counterpart, knowledge, are sadly not so closely related as Bacon would have us believe when he claimed them to be as like "a ray of light and its reflection."

When one forgets the above limitation, common to all theories and theorizing, difficulties of all sorts arise. These difficulties are usually reconcilable through semantic clarification. Every freshman philosophy course has, for example, some problem of this type. One appropriate to our case in point is: "If a tree falls in the woods with no one near enough to hear it, does it make a sound?" This might serve to digest one class period with a good bit of verbal and hopefully mental gymnastics. But, as is often true, the issue is decided by what one means. The term "sound" has two uses, and although related they are quite distinct as to their reference. The psychologist or physiologist is referring to the perception of a physical disturbance of the transmittting media. The physicist, on the other hand, concerns himself only with the physical disturbance itself and its transmission.

Written sensory theory began with Empedocles[8] circa 450 B. C. His explanation of sound perception was the mere application of the principle of resemblances referred to previously. He stated that the organ of perception had miniature duplications of the stimulus which would leak through pores and impress themselves upon the mind. That is, the eye

*Thesis presented by the author while a student in Senior Surgery during the summer quarter, 1965, at The Ohio State University College of Medicine.

The Author

● **Dr. McMahon, Columbus, is a 1966 graduate of The Ohio State University College of Medicine.**

contained light and the middle ear cavity, air. This " tympanic air" was allegedly of a particularly refined type — pure and ethereal. Its origin was explained by Plato[4] to be implanted in utero, an idea it took 2000 years to supplant.

The next major contribution was by Galen, who contributed to the anatomical knowledge by tracing the eighth nerve down its bony path.[8] In the sixteenth century, knowledge of the ear shot forward by great strides with the discovery of the ossicles and the cochlear windows. When Eustachius, in 1564, described the tube bearing his name, the connection between the pharynx and the middle ear cast much doubt upon the implanted air theory.

In 1566, Coiter wrote *De Auditus Instrumento,* the first book dealing specifically with the ear. It was he who denounced the implantation theory. But a century later Perrault revived it by placing the implanted air in the cochlea, a fact incorrectly assumed but widely accepted at the time.[8] At this same time, Schelhammer by armchair theorizing, opposed the implantation theory on the grounds that if air is the conductive medium it cannot also be the percipient agency. He reasoned further, "perception requires that the aerial waves be stopped and their energy changed to a new form."[8] It was not until 1760, however, when Cortugno demonstrated fluid in the cochlea, that the Platonic "implanted air" became fully discredited.[3]

It was in 1605 that Caspar Bauhin, then a student of medicine, formulated his resonance theory of hearing.[1] Due to the paucity of micro-anatomical information available to him, Bauhin was speaking of cavity resonance only; but it is still his theory that one must consider the prototype for that of Helmholtz, which was to follow 250 years later. In this interim, many things were discovered and many mechanisms proposed. DuVerney localized tones along the osseous spiral lamina.[3] At about this same time, Corti described his spiral organ.[8]

It was Helmholtz who colligated these facts and, through his influential position, drew world-wide attention to the resonance theory of hearing. In 1857, the modern period of auditory theory was ushered in when Helmholtz gave his famous public lecture on the scientific foundations of music.[8] By virtue of his public and professional prominence and the development of the theory in connection with problems of musical harmony and perception, a great popular interest was generated. Helmholtz was much impressed by the ear's ability to analyze sound and considered this to be conclusive evidence for the presence of specific resonators in the ear. He appealed to natural reasoning when he said, "When we look about in nature for an analogue of such analysis of periodic motion we find none other than the phenomenon of sympathetic vibration."[8]

As the histology of the ear was clarified, different structures were assigned the resonating function, but none for very long. Later experiments located sounds along the membranous spiral. This increased the resonator theory's credibility and stimulated the proposal of many other "place theories."

Later, but still in the nineteenth century, frequency theories began to appear. The most famous and influential was that of William Rutherford.[3] Here, location of stimulation along the spiral organ was discounted as impertinent. According to him, sounds of all kinds are capable of stimulating any of the hair cells. Sound waves are presumed to be translated directly into nervous vibrations of the same frequency, amplitude, and wave form, and the wave analysis is a higher cerebral function. The ear then becomes a relay mechanism for the stimulus. Interestingly, the upper limit of sound perception at this time was believed to be from 40,000 to 60,000 cycles per second, but apparently Rutherford did not consider this order of magnitude to be any obstacle to the theory.[3] This was probably because of the concomitant lack of knowledge of nerve fiber characteristics. As with the "place theories" before, many variations on the theme of "frequency" also appeared.

For years these two theories (really two groups of theories), place and frequency, opposed one another and proponents of each pummeled the other with invective and occasional experimental corroboration. But much like the corpuscular and wave theories of light, the resolution of the battle lay not in one theory's triumph over the other but in a compromise theory's triumph over "scientistic" jealousy. This compromise has come to be called the Duplex Theory.[5]

Modern Theory

The external auditory meatus has the dual function of maintaining a relatively constant temperature and humidity. This condition maintains the proper amount of elasticity in the ear drum and performs the more physical function of being a tubal resonator. The external auditory meatus can function to increase the pressure amplitude in the optimal range of 2000 to 5500 cycles per second to from 5 to 10 decibels. The sound next encounters the tympanum, which is connected via the ossicular chain to the oval window. Here two more factors are prominent in giving mechanical advantage to the transmission.

First, the areal ratio between the tympanum and the oval window is effectively 14 to 1 (about a 23 decibel gain). Second, since the incus is shorter than the long process of the malleus, vibrations of the oval window are reduced in amplitude but increased in power by nearly 2 to 1 (another 3 decibel gain). This increasing of the power of the vibrations transmitted to the inner ear is essential when going from a lighter conducting medium to a heavier one. Therefore, impedance matching is provided by the tympanic membrane and ossicular system between the

sound waves in the air and sound vibrations in the fluid of the cochlea.

The basilar membrane is resonant with high frequencies near the base and low frequencies near the apex. This is mainly for two reasons — the difference in length of the basilar fibers and the difference in loading by the cochlear fluid. In addition a standing wave is set up in the cochlea. This wave begins at a low amplitude and gradually increases to a maximum amplitude, then rapidly falls from the energy having been dissipated. Another feature of this standing wave is that it travels very fast along the initial portion of the basilar membrane and slows at the end. This rapid initial transmission allows the high frequency sounds to travel farther into the cochlea, spreads them out and separates them from each other on the basilar membrane, facilitating high frequency discrimination.

At the point of maximum amplitude, which is characteristic for each frequency, the hair cells receive the greatest mechanical stimulation. This mechanical stimulation causes a shift of the 150 millivolt potential which fires the proper cochlear fiber. In addition, when the basilar membrane vibrates at low frequencies, at least some of the fibers will fire during each cycle of vibration and electrical recording from the whole cochlear nerve will give a pattern of discharge that faithfully represents the sound frequencies entering the ear. Indeed, even up to frequencies of 4000 cycles per second, a faithful response can still be attained.

So, both the place and frequency theories are partially correct and neither is completely correct. Destruction of the organ of Corti near the stapes destroys one's ability to discriminate high frequency sounds. Destruction of the apical portions of the cochlea does not destroy one's ability to discriminate low tones but does reduce their loudness. Intensity of sound is a function of the amplitude of the basilar membrane vibration, the number of hair cells stimulated, and the stimulation of certain high threshold hair cells.

From the cochlear nerve, the impulses travel to the dorsal and ventral cochlear nuclei, to the superior olivary nucleus via the trapezoid body, then through the lateral lemniscus to the inferior colliculus, the medial geniculate body, the auditory radiations, and finally the auditory cortex. The number of synapses along the way varies from 4 to 6 and fibers may cross over in at least three areas. These cross-overs are probably the central mechanism by which the direction of sound is perceived, relative intensity and phase lag being the criteria for comparison.

Conclusion

We have followed a mechanical wave motion in an elastic medium to its realization in the mind, but the philosophical question has been circumvented. Our experiences of quality, i. e., tone, color, odor and the like are highly indirect appreciations of the properties of physical objects. They are effects produced within ourselves through the translation of physics into biology and biology into psychology. The exact nature of this physico-psychic translation remains unknown. Our senses, the object of our quest and at the same time the instruments with which we carry out the search, may never give up this secret.

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OPERATING UNDER THE PROFIT SYSTEM, the pharmaceutical industry has made enormous contributions to our society. Indeed, nearly all the valuable new drugs of the last 30 years — penicillin and streptomycin are notable exceptions — have been discovered in the manufacturers' laboratories. Since the October revolution in 1917 the state-owned industry in the U. S. S. R. has not produced a single new drug of therapeutic importance. We must therefore be careful not to kill the goose which has laid so many golden therapeutic eggs by excessive bureaucratic restrictions — still less by nationalization. — Quoted from Sir Derrick Dunlop by J. Mark Hiebert, M. D., at the Pharmacy Colloquium, University of Kansas, April 13, 1966.

The Middle Ear

A Simplified Discussion of Some Common Disorders

WILLIAM H. SAUNDERS, M.D.

EACH of the three parts of the ear — outer, middle and inner — has a separate job to do, and each part is subject to different diseases and different symptoms.

The *external ear* is made up of the auricle and the external ear canal. Its disorders usually come from two sources. One is infection of the epithelium, which causes pain. The other is obstruction by cerumen, which may cause partial loss of hearing. Certain lower animals with large external ears — the bat, for example — may improve their hearing by "cocking" them. "Cocking" the auricle enables it to do a better job of collecting sound waves. In man, however, the external ear contributes very little to the hearing process. Mainly, its job is to protect the middle ear.

The eardrum stretches across the deepest part of the ear canal and separates the external ear from the middle ear. It is about as large as the eraser end of a pencil. Actually, it is not as fragile and as easily damaged as most physicians think for it has three layers that make it rather tough. Its outer epithelium is squamous like that of the ear canal, its inner epithelium is mucosa like that of the middle ear. Between is a tough fibrous layer. Besides protecting the middle ear from outside weather and dirt, the eardrum is an important part of the hearing mechanism. This function will be explained later.

The middle ear, which lies directly behind the eardrum, is a small air-filled space in the tympanic portion of temporal bone. In the middle ear are the body's three smallest bones — the malleus, incus and stapes. In it, too, are the facial nerve and the chorda tympani nerve — the latter provides taste for the anterior part of the tongue.

The middle ear has two exits. One, which is blind, leads into the honey-comb of mastoid cells. The other, the eustachian tube, opens into the nasopharynx. The job of the eustachian tube is to equalize air pressure between the middle ear and the throat. To feel how it works, hold your nose and swallow. You will note a sensation of pressure in the ear as the tube opens and admits air to the middle ear. Sometimes you must swallow again to relieve the fullness; this time air is escaping from the middle ear, where it has been trapped under slight pressure. Normally our eustachian tubes are closed. Whenever we yawn or swallow, however, each tube opens a little and brings air pressure in the middle ear to equilibrium with the outside atmosphere.

Submitted November 8, 1965.

The Author

● **Dr. Saunders, Columbus, is Professor and Chairman, Department of Otolaryngology, The Ohio State University College of Medicine.**

The three auditory ossicles in the middle ear form a chain that conducts sound from the eardrum across the middle ear to the oval window. The first bone, the malleus, is attached to the eardrum. It joins the second bone, the incus; an arm of the incus reaches the third and innermost bone, the stapes. The footplate of the stapes which vibrates in response to sound waves, fits in an opening of the inner ear called the oval window. Other parts of the stapes, besides the footplate, include two crura, a neck and a head. A very tiny tendon attached to the neck of the stapes prevents excessive vibration and helps protect the inner ear against intense sound.

The mucosa of the middle ear extends into the eustachian tube and runs along the tube until it joins with the lining of the upper part of the throat. Middle ear mucosa also lines the inner side of the eardrum. It is entirely separate from the epithelium on the outer side of the eardrum, which is derived from skin. Later we will see what happens when skin grows through a perforation in the eardrum and lines the middle ear.

About the Function of the Ear

The *outer ear* affords protection; the middle ear, as we will see later, amplifies sound pressure. But the inner ear contains the organ of hearing and is the only part of the ear with which we actually hear. For protection, the organ of hearing with its thousands of delicate, filament-like processes called "hair cells" is bathed in endolymph. It is contained in a fragile duct suspended in a separate and larger body of liquid called perilymph. Besides protecting the hair cells, endolymph also provides them nourishment.

To understand how the ear works, we must look back millions of years to the time when all animal

life was in the sea. Sounds made in the ocean traveled through seawater directly to similar liquids in the inner ears of aquatic animals. These animals had no external or middle ears; theirs was a simple arrangement. Only a membrane separated the sea from their inner ear. Vibration of this membrane produced hearing.

When animals crawled out of the sea to live on land, many adjustments were necessary. For example, the aquatic ear had to be modified if it were to work efficiently in its new environment of air. When sound pressure traveling in air meets water, most of the sound striking the water is absorbed or reflected back into the air. Thus a fisherman in his boat may talk without fear of disturbing the fish, since 99.9 per cent of the sound energy of his voice is reflected when it strikes the surface of the lake; only one part in a thousand is transmitted to the water. For that very reason, the early land-dwelling animals with their aquatic ears had a hearing problem. The liquids of their inner ear reflected most of the sound energy which originated in their new environment — air. Only 0.1 per cent was effective in producing hearing. To overcome this great loss, the middle ear evolved.

Two arrangements enable the middle ear to work as it does. First, the middle ear bones are arranged in a lever system that amplifies sound as it traverses them. The second and more important amplification results from the difference in size between the two parts connected by the chain of ear bones — the relatively large eardrum which collects sound, and the relatively small footplate of the stapes, which delivers it to the inner ear. You can understand how this arrangement works if you recall what would happen if a woman in high heels were to step on your foot. Her entire weight, transmitted to a tiny area, would drive the heel forcibly; if her weight were distributed more widely by a flat shoe, damage would be less. By virtue of the mechanical advantage provided by the lever system and, more importantly, by the differences in the area of the eardrum and the footplate of the stapes, called the areal ratio, the middle ear regains a great deal of the sound pressure lost in transferring air borne sound pressure to a liquid medium.

When sound pressure reaches the inner ear, the perilymph and endolymph are agitated. The agitation, in turn, causes a commotion of the hair cells. Hearing results. Here is a point that deserves to be emphasized: The only way in which hearing can occur is by stimulation of auditory hair cells. Therefore, any disease that impedes the progress of sound pressure along its route to the inner ear diminishes hearing. But the only disease that causes total deafness or even a severe loss of hearing is one which directly affects the hair cells or their central connections. In other words, no one who has lost his eardrum or even his entire middle ear is totally deaf so long as the inner ear remains intact.

Sound pressure that stimulates hair cells is delivered through the oval window into a solid bony chamber. For there to be effective movement of inner ear liquids and stimulation of the hair cells, there must be a second opening for relief of pressure. The round window provides such relief. What would happen if sound pressure were to meet both round and oval windows at exactly the same time? The effect would be a cancellation; the ear would hear poorly even if the sound were intense. Experimentally, such an arrangement is possible. When two sounds of equal intensity and in the same "phase" are delivered simultaneously to the round and oval windows of an experimental animal, there is no hearing.

Under normal circumstances, however, such a thing does not happen. For as the eardrum collects sound energy and transmits it to the oval window, it also shields the round window from sound. By doing so, it further increases the discrepancy between the levels of sound pressure delivered to the two windows. In disease, when the eardrum is perforated, some hearing is lost because the eardrum, no longer intact, cannot effectively shield the round window.

Some Diseases of the Middle Ear Causing Hearing Loss

1. *Otosclerosis* produces loss of hearing by fixing or immobilizing the footplate of the stapes in the oval window. The cause of otosclerosis is unknown, but it has nothing to do with previous ear infections. The disorder tends to run in families, and it is more common in women than men. Characteristically, the hearing loss starts during the teens, but it is so gradual that patients seldom realize their disability for several years. It gradually worsens over the next 10 to 20 or more years. As a rule, both ears are affected, although often not equally. The new growth of bone about the stapes blocks its movement so that it is no longer free to vibrate effectively in response to sound pressure. At first, there is little interference. In time, however, as the process advances, the stapes becomes so firmly fixed that it cannot move at all. You might think such a patient would be totally deaf since his stapes is useless. Actually, he can still hear very well any sounds brought to his inner ear by "bone conduction." In short, although he hears poorly by the usual route, he hears clearly if a tuning fork, for example, is applied to his skull. Distinguishing between the patient's ability to hear by air and bone conduction is important in diagnosing otosclerosis. When a patient with a *normal eardrum* and a history of *slowly* progressive hearing loss hears as well *by bone conduction as by air conduction,* or hears better —he almost certainly has otosclerosis.

Otosclerosis is an excellent example of a disease causing a serious hearing loss in which hearing can

be restored surgically. Sometimes, in advanced cases, the nerve of hearing has deteriorated. Then an operation is not indicated. Ordinarily, however, the neural apparatus is unaffected.

The surgical problem is largely a mechanical one. With the stapes fixed in the oval window, the surgeon must either break it loose so it can move again, or remove it completely and replace it with an artificial "bone." Most surgeons agree that only to free up the stapes (the "stapes mobilization" operation) is not enough; they think it is better in most cases, to remove the entire bone. Stapedectomy (removing the stapes) is generally preferred to the stapes mobilization operation because, although the mobilization operation restores hearing for a time, the otosclerotic process continues and eventually refixes many of the "mobilized" stapes. Patients with good hearing right after the mobilization operation are disappointed when their hearing later drops back to what it had been. We will not discuss the mobilization operation here. You can better understand otosclerosis and its surgical treatment by learning about the stapedectomy operation.

To enter the middle ear for stapedectomy, the surgeon must turn or reflect the eardrum. With the patient under local anesthesia, he makes a curved incision deep in the ear canal close to the rim of the eardrum. He does not cut the eardrum itself. The back half of the eardrum, freed from its attachment to the bone of the ear canal, is folded forward on itself like an omelette. As seen through the operating microscope which provides excellent illumination and also magnification up to 25 times, the tiny middle ear bones appear large and clear.

In otosclerosis, the footplate of the stapes is solidly attached to the margins of the oval window and, at operation, pulling on the head of the stapes usually does not remove the entire bone; instead, the crura break off at the footplate. Head, neck and both crura lift out, but the footplate remains fast. So, to dislodge and remove the footplate (size 1 by 3 mm.) sometimes in one piece, sometimes in several, the surgeon uses a fine needle, various picks or hooks, an electric drill, or a combination of these instruments.

Once the footplate is out, the surgeon must seal the open oval window. An older method was to use a piece of vein from the back of the hand. Placed in the ear, the vein grows across the window as a graft. It not only seals the liquids of the inner ear, but it also forms a vibrating diaphragm for sound transmission. But even with the obstructive footplate out and the vein graft across the oval window, the sound conducting mechanism is still not restored. With the stapes gone, there is no connection between the incus and the inner ear. The final step, then, is to link the two with a plastic or metal "piston." The surgeon places one end of the piston so that it dimples the center of the vein graft. He slips the other end under the incus. The piston conducts sound from incus to vein graft, and the system is complete.

There are other newer and equally good ways of conducting sound from incus to inner ear. After the stapes and its footplate have been removed, the surgeon can use a preformed loop of wire to which a pad of Gelfoam® is attached. One end of the wire is crimped over the incus while the Gelfoam on the other end seals the oval window. Later, as the Gelfoam absorbs, a membrane forms across the oval window and incorporates the end of the wire in itself. In that way the wire attached to the incus becomes a plunger-like mechanism for sound transmission.

After stapedectomy, hearing improves in the great majority of patients. This is not to say that completely normal hearing is restored, although often it is, or that in a rare instance hearing may not become even worse. Stapedectomy is done on only one ear at a time. The patient's course after operation is ordinarily smooth, but an occasional patient may experience vertigo for a few days. The usual hospital stay is for two or three days.

2. *Middle ear infections* also cause loss of hearing. If the infection is new, it is called "acute"; medical measures, such as administration of antibiotic drugs, usually cure the patient and restore hearing. If the infection has been present for months or years, it is called "chronic"; then medical measures usually fail, and surgical treatment is required. Often patients with chronic ear infections have tried all sorts of medical treatments, including antibiotics and eardrops, and they have consulted a number of physicians. The patient's ear drains most of the time, and often the drainage is foul.

A chronic ear infection started with an acute upper respiratory infection. The infection produced pus, and when the eardrum broke under its pressure, pus drained from the middle ear into the external ear canal. When the pressure was relieved, the earache was relieved; but the infection failed to clear, and the patient was left with a perforation in his eardrum. After a time, the squamous epithelium that normally lines the outer surface of the eardrum and the ear canal grew through the perforation into the middle ear and into the nearby air spaces of the mastoid bone. Why "skin" from the ear canal should grow into the middle ear where it doesn't belong is not clear, but when it does "skin" lines part of the middle ear and mastoid. Elsewhere on the body dead skin peels off. It doesn't collect because it is on the surface and gets washed or rubbed off. But in the ear where the dead skin can't get out, it forms a soft white ball called *cholesteatoma.* Growing larger, year by year, the cholesteatoma destroys bone and sometimes interferes with the function of nearby structures. Some of these adjacent structures such as the facial nerve or cochlea are important, and others, such as the meninges are even vital. In

short, a patient with an expanding ball of cholesteatoma is in danger of developing a complication of middle ear disease.

Not every patient with chronic disease of the middle ear and mastoid has cholesteatoma. Some just have infection; others, however, have both cholesteatoma and infection. In a few patients, the eardrum perforation is large enough to permit adequate cleansing of the abnormal skin-lined cavity, although usually it is not, and almost all patients with cholesteatoma are surgical candidates. At this point it is worth emphasizing that there are still other patients with perforations of the eardrum who have no active disease and no symptoms except a mild or moderate loss of hearing. In them the middle ear has remained normal, no skin has grown in the ear, and they are in no danger.

When it is apparent that medical measures cannot clear a patient's chronic middle ear infection, his physician may advise him to have an operation. Several different operations are designed to eliminate infection or to restore hearing in patients with ear infections. The aim of all operations should be, first, to eliminate infection, and second, to restore hearing if possible.

The radical mastoidectomy operation, an old and still excellent procedure, converts the draining, dangerous ear into a dry, safe ear. Usually by the time the radical mastoidectomy operation is indicated, hearing is already at a non-serviceable level. Removing remnants of the eardrum or middle ear bones, then does nothing to worsen hearing. It is a popular misconception that we cannot hear without the eardrum. That, of course, is not true since the only conditions that cause really severe deafness are those which destroy the neural part of the hearing mechanism. Radical mastoidectomy leaves a large defect in the temporal bone and this cavity is apt to become superficially reinfected and so after radical mastoidectomy many patients have trouble with intermittent aural discharges. *Modified radical mastoidectomy* is done when the disease process is limited and when there is likelihood of saving useful hearing.

Tympanoplasty is the name of a group of relatively new operative procedures to restore the middle ear and to attempt to improve hearing in patients who have had chronic ear disease. Other occasional uses for tympanoplasty include ears injured by trauma or by congenital defects. For the most part, however, tympanoplasty in its several forms is used to repair a perforation in the eardrum which resulted from old infection, or to restore the function of the middle ear in a patient who, formerly, would have had to settle for mastoidectomy and poor hearing.

3. *Obstruction of the eustachian tube* produces yet another type of middle ear hearing loss. The tube often blocks during an upper respiratory infection when the adenoid tissue or mucosal lining of the tube swells. Children, especially, are afflicted in this way because of their relatively large amount of adenoid tissue. The blocking keeps air from entering the eustachian tube whenever the patient yawns or swallows, and the capillaries absorb what little air there is in the middle ear. As a result, there is a partial vacuum in the middle ear. Blood serum, seeping through capillary walls, offsets this negative pressure. But as blood serum fills the middle ear, it has a damping effect on movements of the eardrum, which no longer vibrates against an air-filled middle ear but against one partly or even completely filled with liquid.

This condition is less common in adults than in children because adults have larger tubes and also less adenoid tissue to block the tube. Even when adenoid tissue is absent, however, obstruction of the eustachian tube can result simply from swelling of the membranes that line the tube itself. Sometimes, after rapid descent during air travel, one's ears are "blocked" and they fail to clear as usual. If such a "block" persists, serum may collect behind the eardrum just as in the child with adenoidal obstruction.

If the condition is recurrent, the treatment is to remove the adenoid. Ordinarily this operation solves the problem. Occasionally, though, especially in children who come from families with allergies, the adenoid regrows and the adenoidectomy must be repeated. The surgeon can easily remove all of the tonsil because it is surrounded by a capsule or membrane, but he finds it difficult or even impossible to remove all of the adenoid because it is not so contained.

The child who has tubal obstruction from time to time is likely to have recurrent episodes of hearing loss. When the tube is obstructed, hearing is down; when serum drains and air is admitted to the middle ear, hearing improves. In short, the hearing fluctuates.

Another procedure, now used very commonly, is the insertion of a small hollow plastic "button" through the eardrum. The "button" has a cuff on each end. The inner cuff fits just inside the middle ear to prevent the button from falling out. These buttons, which admit air to the middle ear, may be left in place several weeks or even several months.

Parents often think the hard of hearing child, particularly if he has trouble only intermittently, is just not paying attention. But for a child of normal mentality, that is never true. Children are curious and astute; when they seem to be hard of hearing, they are.

In addition to these comomn disorders of the middle ear, there are others which are less common. Diagnosis in all cases depends upon careful otologic and audiometric examination. In general there is available medical or surgical treatment for most disorders of the external and middle ears while most diseases of the inner ear do not respond to treatment.

Psychiatric Aftercare

A Discussion of the Importance of Predischarge Planning

THEODOR BONSTEDT, M.D., and HOOSHANG KHALILY, M.D.

I. Introduction

THE TITLE of this paper contains some terms which probably ought to be explained beforehand. The "predischarge planning" refers to a continuous plan of treatment of a psychiatric patient, a plan which is worked out by his psychiatrist, usually in collaboration with other professional people in the hospital and community, concerning what will be done with and for the patient prior to and after his discharge from the hospital. The term itself is meant to imply that such a plan is to be conceived and be ready for implementation before an order for discharge from the hospital is issued. Some authors use the term "postdischarge planning"[1]; we prefer our term as it emphasizes the necessity for planning to be done early in the course of hospitalization.[2]

The concept of "aftercare" is so relatively new that the term is not even included in the psychiatric dictionary by Hinsie and Campbell (1960) nor in "The Psychiatric Glossary" of A.P.A. (2nd Ed., 1964). In common usage, it refers to the totality of treatment and rehabilitation efforts on behalf of a recently discharged psychiatric patient (the discharge having taken place within a short period prior to the time when the "aftercare" is begun). Thus, this concept is essential for the continuity of care and treatment, as some kind of attempt to build upon and enlarge the gains previously made in the treatment of the patient while he was still hospitalized.

It is also important to consider the background of our discussion within the context of our particular time. This happens to be a time when the so-called "community psychiatry" is coming to play an ever more influential role in any mental health planning, with a stress being laid on the comprehensiveness of mental health care. It is a time when our Federal Government, for the first time, has not only called attention officially to the importance of mental illness but also has been advocating a model of a "Community Mental Health Center." This Center is conceived not as some new organizational or physical structure that would replace any of the previously existing facilities, but rather as a local network of already existing agencies, and perhaps some added new ones, all coordinated in such a way as to leave no gaps in treatment experience of the patients as they are moving from one agency to another.[3]

It is understood that each new agency will provide for the patient that which he needs most at the particular time; also, that the agency will be the best one qualified to do so; and finally, and this perhaps is the most important modern change or trend, that the continuity of treatment as experienced by the patient will be secured by the professionals working with him previously. All too often it was, and in the majority of communities still is, a situation where the patients would receive the best of care from one agency and then would be given proper and conscientious advice upon discharge, to apply in turn to certain different agencies in the community (for instance, a mental health clinic, a family service agency, a rehabilitation agency, etc.). Each new agency in turn would have its own procedure of application, screening, and requirements of admission. The inevitable result has been what some people have come to call "a game of musical agencies" in which patients would be sent from one agency to another only to experience repeated rejections for the very valid local reasons of their being ineligible under the existing circumstances.

To put it in another way, there exist in nearly every community some important gaps in the available spectrum of services, these gaps being usually centered around certain "problem" patients or clients such as alcoholics, borderline mentally deficient, adolescents, and certain types of sexual sociopaths. Patients subjected to this frustrating and time-consum-

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ing procedure of trying to find the proper agency (when none of the existing ones seem to offer service quickly) would as often as not relapse and reach a stage where they would be more disturbed and had to be still more dependent on their communities, oftentimes being sent back to the psychiatric hospital. Meanwhile, each agency would feel that it certainly is doing its best with what resources it has available. It is precisely the realization of this type of poor coordination, and an attempt to overcome it for the best of our patients, which is a part of the modern trends in the so-called "community psychiatry."

When it comes to medical agencies in particular, the comments which were just made would mean to a community-oriented psychiatrist two things: first, that until now, these medical agencies have faithfully followed the "medical model." By this is meant the traditional approach of general practice and other specialties, in which by and large the physician sees himself as the one crucial person who is to plan the treatment for his patient, who decides when to terminate it and to release him — "after the maximum benefit of treatment has been reached" — back to his regular life. Thus, when today in modern mental health planning we are trying to become community oriented for the aforementioned reasons, is also means that in a sense the traditional "medical model" would have to be somewhat modified in accordance with our understanding of the important social forces at work in the lives of our patients and our willingness to adjust ourselves in the planning of treatment to this newly won understanding.

II. Historical Review

It is well to remember at least the more recent American history on this subject, in order to understand better the position taken today. Until the second half of the nineteenth century, there was no specific planning for the mentally ill on any significant scale; rather, they were thrown together with the other "liabilities of the community" (the poor and the delinquent) in alms houses and jails. Thus, it was a responsibility of the local community but without specialized planning.

In the second half of the nineteenth century, the state governments took upon themselves the task of providing the best treatment which was then known for the mentally ill — isolation for custodial care in large centers away from the local communities of most of the patients. The isolation was not broken by the revolutionary ideas of Freud, which permeated the psychiatry of this country in the first half of our century, since treatment of patients was continued to be conceived in terms of the "medical model" (Freud himself spoke, eg, of how he felt at a loss with relatives of patients, who are like meddlesome spectators at a delicate surgical operation). The psychoanalytic model of treatment through relationship required so much time and manpower that under the existing circumstances the large masses of patients in state hospitals had to remain isolated with primarily custodial care.

It was during the 1950's that a decisive change began to take place, with a wide use of the new tranquilizing drugs. For the first time in American history, the census of patients in public mental hospitals began to decline, and people who until then were doomed to an indefinite stay in long-term psychiatric hospitals began to return to the community. With this then came the new problem of "aftercare" on a large scale. Today it continues to command a great part of our attention and efforts in the mental health field.

By coincidence, it was also during the 1950's that studies of group dynamics and social forces came into prominence, further weakening the assumed adequacy of using the medical model in this area of psychiatric endeavor. Psychiatrists quickly learned the frustration of seeing their patients discharged in seemingly good spirits and then seeing them return "crushed" by the effort of living in the original local community, where stresses of their family life, job, and school situation remained unchanged. An official expression of the professional and national concern with these matters was given in the creation of the Joint Commission on Mental Illness and Health which worked for five years and produced "Action for Mental Health" report (1961) — indeed an historical document pointing up the need for modifications in our approaches to mental health problems in this country in general, and to problems of aftercare in particular.[4] The report underscored the necessity of psychiatric help in the *local* community, spotlighting the locally existing shortcomings, and initiating various attempts to orient and mobilize local communities toward better mental health services.

III. Current Difficulties

As the new influences in the field of mental health are beginning to be felt across the country, the inevitable result is that local situations represent quite a scatter or diversity of what actually is being done for the psychiatric patients. With respect to aftercare, in many quarters the medical model is still followed faithfully in that the patient is simply discharged from the psychiatric hospital with the hope, expressed or implied, that somehow another hospitalization would not become necessary. He then goes on and tries to do this much on his own, but does he succeed? In a paper presented at the A. P. A. Meeting in 1964 entitled "Aftercare: The Uncrossed Bridge," the author states:

> The increased rate at which patients are leaving mental hospitals has been one of the major achievements of our profession in the past two decades. The deplorably high rate at which they return — often repeatedly — remains one of our major unsolved problems.[5]

This has also been our experience and impression. It led us to take a searching look at predischarge

planning in several accessible psychiatric hospitals. The following clinical situations were chosen to highlight the subsequent discussion.

Case 1. For several weeks prior to discharge of a patient, her social worker (with the knowledge of the attending psychiatrist) was making plans to have this patient enlist the help of a local family service agency immediately following discharge. This was felt to be the most appropriate solution under the circumstances of her particular problems. A week after discharge, the social worker was startled to see this patient in the Outpatient Clinic attached to the hospital, and upon inquiry she found out that the patient was told by her hospital doctor to make this appointment for follow-up in the Outpatient Clinic (which in such a case had to mean transfer to one of the psychiatrists attached to the Clinic). Needless to say, the patient seemed as bewildered as was the social worker.

Case 2. A man in his fifties had been followed as an outpatient by a psychiatrist for two years, but due to an intercurrent increase in stress (and concomitant increase in symptoms of agitation, insomnia, suicidal preoccupation) psychiatric hospitalization was recommended. The patient was hospitalized and the information was left on admission forms that the referring psychiatrist would be glad to follow-up this patient after discharge, as such would probably seem advisable. However, the patient should not be permitted to follow any impulse to leave the hospital as quickly as possible. The referring psychiatrist was startled to see this patient on his daily appointment roster some three weeks later, with no prior message from the doctor or social worker who were in charge of this patient while he was in the hospital. From the patient's story and from the study of the hospital record, it appeared that he twice signed the notice of discharge against medical advice, and the second time he could not be persuaded to withdraw the notice. Thus administrative approval for discharge was given (as his being in the community represented no great risk at the moment), and there it ended. The original psychiatrist had to make momentary decisions entirely alone, without the benefit of the experience obtained in the hospital.

We wish to make it clear that it is not our intention to single out the individuals or hospitals that may have been involved in these or similar cases. This kind of failure of communication is baseline of attempts to clear up inter-agency difficulties in communication as they are bound to occur between the discharging hospital and the outside agencies. From our experience, it appears reasonable to assume that patients with similar "preparation" appear in many medical and paramedical agencies of various communities following their psychiatric hospitalization. On the other hand, it should be emphasized that in order to improve this situation, some kind of broad, long-range coordination of treatment efforts would be necessary. It would miss the point if we were, eg, simply to attempt "screening of all patients to be referred to Clinic X." The need here is not just for "screening" on behalf of one agency. It is an issue of how best to help patients in using all kinds of agencies in our communities (including psychiatric clinics) through all kinds of actions (including screening — but also taking care of relaying information, establishing proper contact, assuring this continuity of proper care by all available means).

IV. Optimal Model of Predischarge Planning

Let us now see how this new understanding can be put to work in a psychiatric hospital setting in such a way as to increase the efficiency of treatment. Inasmuch as this approach is characterized by its long range (in time) and its comprehensiveness (in terms of taking into account all factors infringing on patient's fate and using them therapeutically), the planning for what should happen at the time of discharge and afterwards will have to start early in a patient's hospitalization — technically, as soon as the diagnostic formulation has been worked out and general treatment plans are formulated. The very initial decisions about treatment to be given in the hospital should include thinking about the future.

If drugs are going to be used, is this the kind of patient who will depend on them and who will avoid sharing any important feelings in psychotherapy? Will he thereby succeed in leaving the hospital as unprepared as before to meet the community stress? He will, unless, at the very beginning, individually tailored corrections are made, such as ordering drugs of a type and in such a manner that this particular dependence could not be established.

If psychotherapy is to be used, is this perhaps the patient whose problems are to a large extent rooted in realistic family factors such as a hostile spouse, and if so, will he be prepared to meet this stress after discharge? He will not be unless, while the patient is in the hospital, pressure is exerted upon the family to come in for casework. Experience has shown that, if the same pressure is applied after the patient is discharged, the families of patients are much less motivated to respond. Since the crisis in their lives connected with the hospitalization has just passed, why should they undertake the unpleasant effort of exposing themselves to remedial casework?

If this is a patient whose problems lie mostly in the area of the real social factors of vocational skills or difficulty in finding employment, would it not be best to discourage his interest in sharing much intimate material with the doctor even if he happens to be so motivated, and if he appears "interesting"? Would it not be better to begin, while he is still in the hospital, making contacts with a community agency which could subsequently help him with such a vocational problem? The facts of life are that such agencies are few and far between. They have their own complicated and involved procedures of application and admission and usually take several weeks to process a case. These will probably be, without proper predischarge planning, precisely those weeks immediately following discharge when the patient would once more experience the same stress and, just as unprepared, might have to be rehospitalized.

It was mentioned already that the period of hospitalization is the stretch of time during which the relatives of the patient are much more likely to cooperate in discussion and agreement on plans for future follow-up and treatment after discharge from the hospital. The same is true about community agencies such as schools, employers, and family physicians, to name only a few. A high school teacher

is likely to react less favorably if a few days after discharge from the hospital she meets her teenage pupil in the midst of some odd behavior on his part, and then only she has to find out that there is a psychiatrist involved, and she has to call him asking for advice. In this situation, the teacher more likely will send a desperate message, eg, "we shall absolutely not have him here unless you, as a doctor, first guarantee that he is not going to do these various things of which we are afraid."

How much easier is it by comparison — and how much more efficient — for a psychiatrist who treats this same patient in the hospital to call the teacher some weeks prior to the planned discharge and to have a conference. Here, first the problem is described as it is seen by the teacher and the psychiatrist. Then the psychiatrist spells out his advice and gives his reassurance to the teacher concerning all those practical classroom situations which puzzle and worry the teacher. Obviously, in the latter case, the likelihood of avoiding repeated breakdown is greater. Situations with employers and supervisors on the job are very much similar to the school situation on all the listed points.

But what about the family doctor? It has been reported by several nationwide surveys that the general practitioners have complained about the way psychiatrists do not brief them about the progress of their patients in psychiatric treatment (in particular at the time of discharge from the hospital). The possibility will have to be considered early in planning for his discharge whether the patient might benefit from a general practitioner whom he had seen previously, and who understands him and his family. Psychiatric manpower is not only generally scarce and more expensive but it also often carries with it a stigma. Furthermore, the patient may require a concomitant treatment by a family physician for the concurrent physical illnesses. Whether as a partner on the therapeutic team, or as the only physician involved, the family doctor will need a close contact through sharing of information by the hospital doctor not only about the diagnostic impression at the hospital but also about the treatment used, an explanation about the future expectations, and advice on how to deal with foreseeable complications. Many cases of patients getting along well on chemotherapy and "pure support," and not well suitable for intensive psychotherapy, are best treated by general practitioners. Referring such patients routinely to a psychiatric clinic for aftercare creates a situation in which other patients, who would need a more specialized outpatient skill, have to be refused for lack of available professional time.

We hope to have shown by now why it is indeed necessary for the best progress of our patients that this planning for help to be offered after discharge would take place early during the hospitalization and that information would be shared ahead of time with those professionals who will next care for the patient. This is the essence of the principle of "continuity of care." If someone were to attempt to do it within the last few days of the hospitalization, he would find that it is already too late. In most of the cases, the appropriate agency would not find it possible on such short notice to do a meaningful contribution to planning, such as giving advice about still other agencies or trying to expedite the patient's application.

If any extramural agency is to be consulted, it should be done early enough in the hospitalization when all the factors involved in future planning (beginning from patient and his relatives and on to type of treatment and auxiliary resources) are still available for free manipulation and adjustment of attitudes. From this it follows that early in a patient's hospitalization, when his case is being discussed within the hospital staff, careful attention should be paid to the predischarge planning as it is outlined in this paper. This properly timed planning cannot be substituted by even a most thorough letter or message of referral at the last minute to the professional person about to take over responsibility for the discharged patient, even though it is true that such transfer message to any extramural agency is a professional necessity without which the treatment of a patient receives another blow with resulting lack of continuity.

The realization that continuity of treatment is lacking, and that our efforts are not the best they could be, can be made only by the psychiatric professional. Patients may feel a vague dissatisfaction at such discontinuity, but they will be unable to question the whole mystifying and specialized complex of medical procedures in any of its parts. Thus it comes to be that a system without adequate predischarge planning may "work" in the sense that there will be no specific complaints and the totality of failures will be ascribed to other causes. It is up to the psychiatric profession to recognize this particular contributing cause. This has been done in some training centers, at least one of which has documented this recognition with appropriate research.[2]

From all that has already been said, it can be seen that where the same doctor continues to see a patient after discharge, some of the difficulties of the predischarge planning will be automatically overcome. This is one of the reasons why follow-up of one's own discharged patients is always encouraged. Not only is it best for the patients, but in psychiatrist's own training and experience it results in a more complete exposure to the successive realities of treatment, rather than in a fragmented experience: "Until now I have been in charge and now somebody else will take over and I don't have to worry about it." It can usually be shown that, where a doctor expects to follow up a particular patient after discharge, he

is also likely to be more careful in preparing for discharge.

There is at least one well documented research project which shows what happens when aftercare is offered without preparation and generally without securing a continuity of care from the intramural program to the extramural efforts of psychiatric agencies. The project is commonly referred to as "The Denver Aftercare Study."[2] Using a design in which continuity of care was absent, the author states:

We found that the patients who participated in our aftercare program did not vary significantly in their hospital readmission rate from the control group who received no aftercare. In attempting to understand the apparent lack of effect of our aftercare program in contrast to the published results of other programs, we were most impressed with the many instances in which the discontinuity of care in our study seemed to be the most obvious relevant variable.

This author also states that

the most critical period for our patients fell within the first several months following discharge, and this was the time when we were of least help to them. The aftercare offered was not infrequently refused or rendered less effective because of the patient's suspiciousness of an unknown person. Aftercare planning did not precede discharge. Inter (and intra) agency communication was not adequate.

And still further:

Without the benefit of predischarge planning and continuity of patient care, in our program it took from four to six weeks (and sometimes longer) after discharge before an individual rehabilitation program could actually be put into operation. We concluded that this was much too late, for by this time many patients had already begun to experience an exacerbation of their symptoms. We soon began to appreciate the difficulties that our discharged mental patients were experiencing, not only because of their lack of awareness of community resources, but also in following through on referrals to the proper agencies. Simply telling them where to go was not enough. It is probably only the healthier patients who are able to utilize agency referrals on an independent basis. Some of the services which agencies stated to exist actually do not exist in practice, or if they did, it was difficult for psychiatric patients to meet their eligibility criteria. We now feel that in any aftercare program it is essential that the social worker be more strongly identified with the patient than the agency. In our experience, the social worker who is most likely to do this is the social worker who has known the patient for some time.

The discharge information which we received from the hospital into aftercare program was in too many instances incomplete, outdated, or simply erroneous. . . . We concluded that an ideal aftercare program should be a planned integral part of the intramural program of the hospital. There should be as much continuity of care as is possible. and the same staff who treats the patient in the hospital should if at all possible, follow through with the aftercare program.

Summary

We hope to have shown with this presentation that properly planned and effective aftercare, as the most important aspect of treatment beyond hospitalization, has to start with an adequate predischarge planning. This must be timed well in advance of discharge from the hospital — as soon as diagnostic evaluation is made, and plans are shaped for treatment within the hospital. This in turn can only be achieved where the professional staff deliberately attempts to secure a maximum continuity of care, as by maintaining the same treatment team for any given patient after his discharge, or by securing early and thorough consultative involvement with the extramural professionals who are to take over the care of this patient at a later date.

Acknowledgment: The authors wish to express their indebtedness to Lowell O. Dillon, M. D., Superintendent, Rollman Psychiatric Institute, Cincinnati, Ohio, for his help in reading and correcting the manuscript.

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AFTERCARE OF STATE HOSPITAL PATIENTS. — Of all the problems facing patients released from a state hospital, the most serious one is adjustment. Failure here means a return to the hospital. The present aftercare program of the Department of Mental Hygiene does not and is not intended to meet all of the patient's needs. It must rely upon other agencies to assist. It must rely upon the general practitioner to provide the continuity of care which is so important to successful rehabilitation. The general practitioner can often make return to a state hospital unnecessary by an accurate assessment of the patient's problems, by effective intervention, by utilizing available consultation and by judicious referral. When services are not available, he can do much to make them available through the effective use of his professional channels. — Elmer F. Galioni, M. D., Sacramento: *California Medicine,* 104:22-25, January 1966.

Placental Localization

DONALD W. SHANABROOK, M. D.

VAGINAL bleeding in the last trimester of pregnancy is a serious complication, and placenta previa is one of the common causes of this problem, the incidence being one in about 200 pregnancies.[1] Maternal and fetal welfare can be jeopardized by injudicious management of a placenta previa condition.

The most characteristic symptom of placenta previa is painless hemorrhage in the last trimester of pregnancy. The most common sign of placenta previa is a soft, succulent cervix with a patulous external os, through which the characteristic sponge like placental tissue can be palpated. However, in the diagnosing of placenta previa, there is the danger of massive hemorrhage by disturbing the placenta with vaginal examination and palpation. Vaginal bleeding can be so profuse as to cause maternal and/or fetal death in a matter of minutes. In fact, Eastman has stated that placenta previa has caused massive vaginal hemorrhages, but he is unaware of a case in which this occurred without previous vaginal examination.[2]

Clinical experience with low lying placenta has demonstrated two basic facts: the initial hemorrhage is rarely, if ever, fatal; rectal and vaginal examination often precipitate severe hemorrhage. Therefore, it behooves us to find a safe method of placental localization without vaginal examination so that definitive treatment may be carried out in the case of a pregnancy at or near term, or expectant management may be attempted in the case of a premature infant to gain time and increase fetal survival.

There are many methods of placental localization, most of which leave something to be desired, either in safety or accuracy. Most of these methods subject the patient and fetus to large amounts of ionizing radiation and are 10 to 20 per cent inaccurate, especially in the first half of the third trimester of pregnancy.[3] However, the use of isotope localization by the Saint Luke's Obstetrics Department and Nuclear Medicine Laboratory has demonstrated this to be a safe, accurate, and practical method of placental localization. Radioisotopes were first used for placental localization by J. C. McClure Brown in 1951.[4] The technic was further perfected by Weinberg in 1957, using radioactive iodine-labeled human serum albumin.[5] This is considered a more suitable tracer than radioactive sodium as used by Brown because it remains in the intravascular compartment for sufficient time to make careful and repeated counts, and its half-life is sufficiently short to prevent excessive radiation.

Submitted September 3, 1965.

The Author

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Method

The patient is placed supine on a table and 5 microcuries of *radioactive iodinated serum albumin* are injected into the antecubital vein. The abdomen is marked into nine equal squares (Fig. 1) during the ten minutes required for equilibration of the tracer substance in the intravascular space. A recording is taken over the xiphisternum for one minute and recorded as representative of the cardiac pool, and a baseline. The probe mounted on a counter balanced arm is adjusted at the skin surface by hand to record in the anterior posterior plane. Following this, a count is taken over each abdominal segment for one minute. The count is repeated in each abdominal segment in reverse order in an attempt to reduce variation by averaging the two counts.[6,7] A 2 by 2 inch sodium iodide crystal scintillation counter was utilized

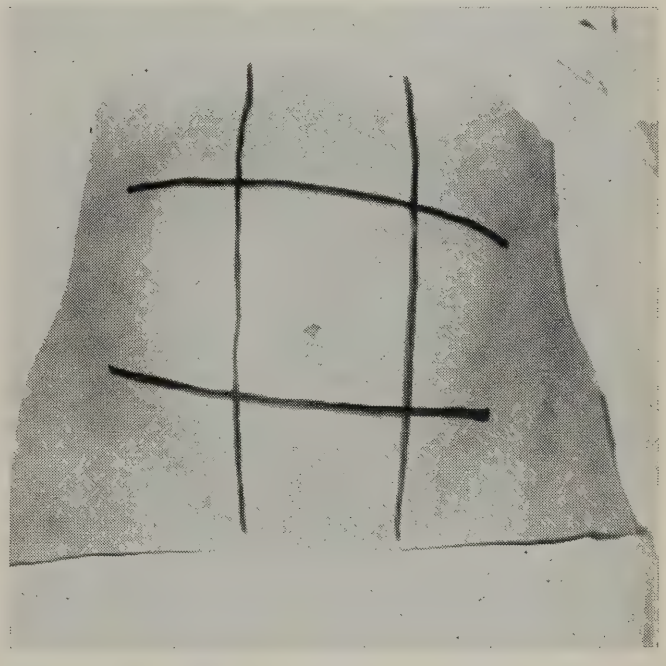


FIG. 1. *The uterus is palpated through the abdominal wall and its size and shape is determined. It is divided into nine approximately equal segments by marking the abdomen.*

for this procedure. The signal from the detector was received directly by a "Nuclear Measurement Corp. Decade Scaller 1-A."

The calculations required are illustrated in the following case. A 26 year old white woman, gravida II, Para I, was admitted to Saint Luke's Hospital at 32 weeks gestation because of mild vaginal bleeding without pain. In performing a placenta scan, the abdominal and xiphisternum recordings were noted and averaged as follows:

Xiphisternum	1724		
	1908		
	1816 average		
Abdomen	1683	1663	1689
	1760	1761	1587
	1721	1712	1643 average
	1600	1761	1790
	1575	1651	1709
	1587	1709	1749 average
	1646	1937	1859
	2055	1996	2030
	1850	1966	1944 average

The average abdominal section counts were then expressed as a percentage of the xiphisternal cardiac pool as follows:

$$\frac{1721 \times 100}{1816} = 95\%$$

The other segments were calculated and a diagram constructed as in Figure 2.

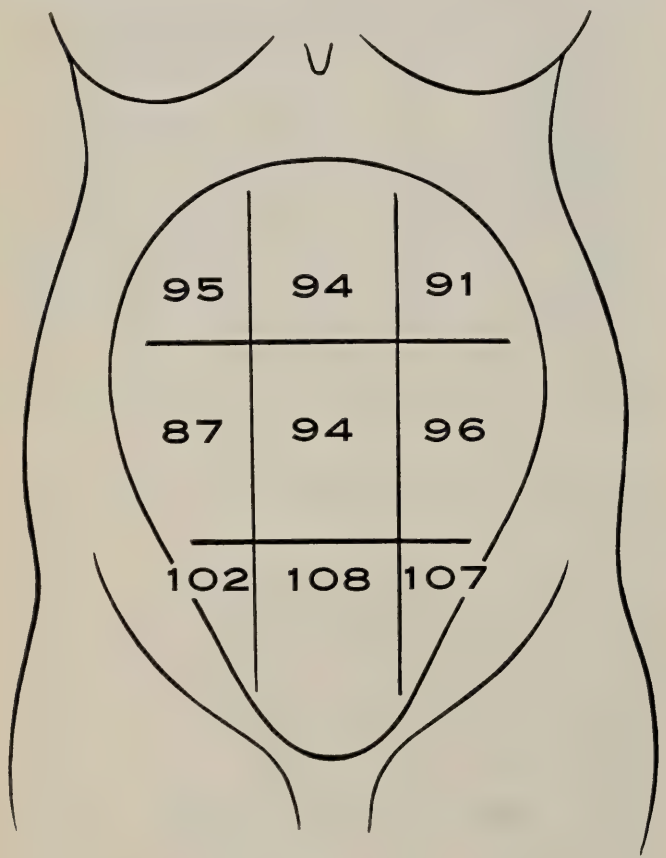


FIG. 2. *The percentage in each segment is figured and the location of the placenta becomes apparent by placing the percentage figures in a diagram, and utilizing Cavanagh's rule.*

The average of the highest and lowest abdominal segment percentage was noted. According to the formula of Cavanagh, a reading in the three lower uterine segments which exceeds this average is significant and indicates placenta previa.[8] In this case again the average of the highest and lowest abdominal segments was

$$\frac{87\% + 108\%}{2} = 97\%$$

The lower segments in Fig. 2 were all greater than 97 per cent, indicating the presence of a placenta previa. A total placenta previa as indicated by the placenta scan was confirmed with abdominal delivery three weeks later.

In some determinations, we have also added another segment not described by other authors. This consists of a probe directed toward the lower abdomen through the perineum. We have found it useful in further confirming the evidence of a total placenta previa. The large amount of blood containing radioactive iodinated serum albumin in the maternal sinus directly under the placental implantation site is believed to localize the placenta.[9] Should difficulty arise in interpretation of the results, the counting procedure can be repeated without re-injection for as long as one to two hours.

In Fig. 3-a-b-c are examples of typical placenta-

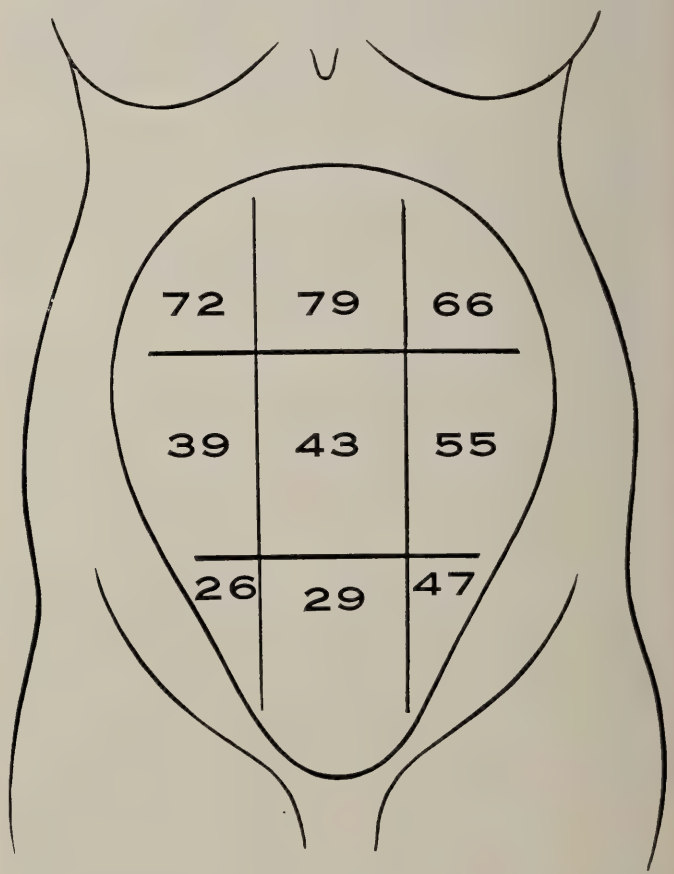


FIG. 3-(a). *Placental localization is also useful in placental sites other than the lower uterine segment. Localization is often a desired requirement in fetal transfusions and amniocentesis procedure. This placenta was confirmed as fundal in location.*

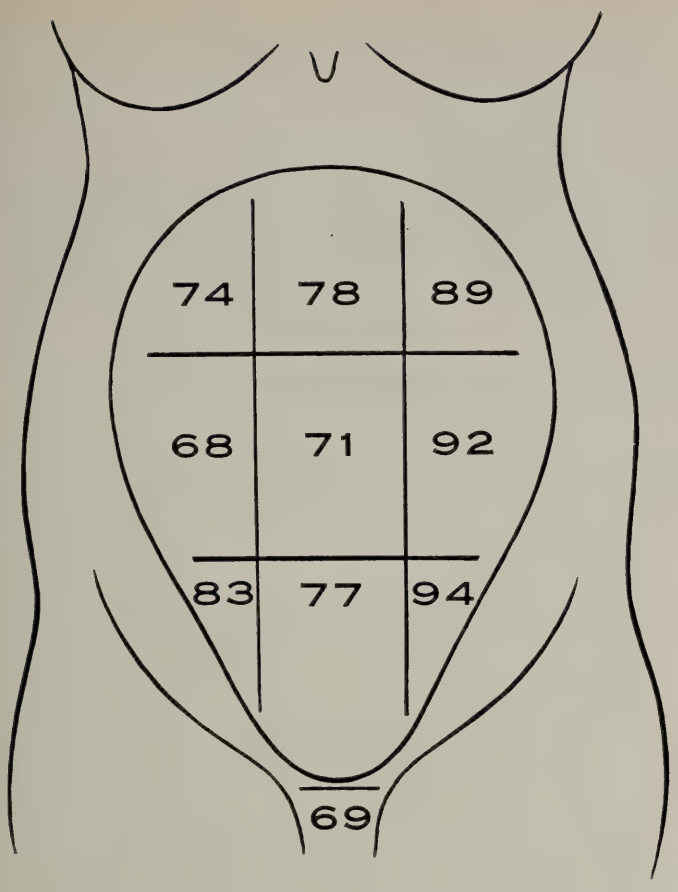


FIG. 3–(b). *Placentascan can be very accurate indeed, here a low lying lateral placentation site was found.*

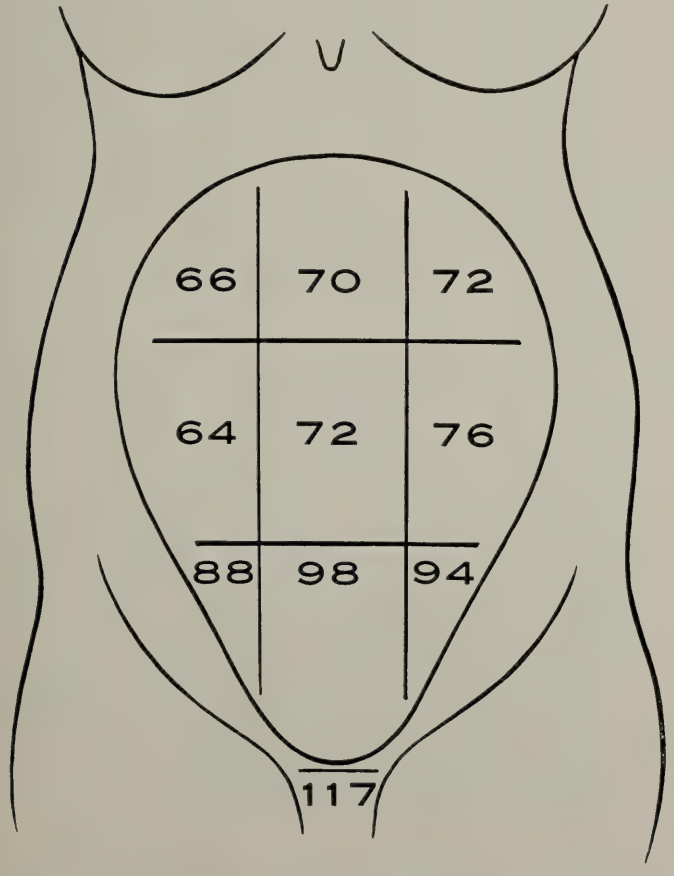


FIG. 3–(c). *The use of the perineal segment confirms a placenta previa in this case.*

scans that were obtained and confirmed at the time of delivery.

Results

There have been 20 placentascans, using the technic described, performed at Saint Luke's Hospital. The placenta site was not determined after delivery in two of these cases, and both were vaginal deliveries. In one, a fundal placenta was predicted, and the patient delivered without any complications. In the second case, the patient had a clinical history suggestive of placenta previa. On placentascan, a diagnosis of low lying anterior placenta was made. The patient delivered vaginally, with moderate intrapartum bleeding, and no total placenta previa was found. However, after delivery, the placenta delivered spontaneously before the placental implantation site could be determined. Tabulating these two cases as failures, the accuracy of this method is 90 per cent.

In none of the studies was there a finding of total placenta previa where none was predicted, and this also held true for the converse situation. Therefore, in 100 per cent of the cases, the study answered the question concerning the absence or presence of a total placenta previa without vaginal examination.

We also had an interesting placentascan in a patient at 30-32 weeks' gestation, in which the results indicated a placenta previa and a fundal implantation. At cesarean section, the sites of implantation were as indicated in the placentascan, as this was a twin gestation.

Comment

We have here a diagnostic method, which can be used to obviate many of the dangers of diagnosing placenta previa.

Some difficulty has arisen in interpretation as to whether the placenta is located on the anterior or posterior uterine wall, especially with a fundal implantation. Counts taken over the flanks can help with this problem. However, in the management of placental previa, this is not of primary importance. Accuracy in deciding whether the placenta is located in the lower segment is what is required, and our success is 90 per cent in this series. Knowledge of the placental location helps the management of placental previa immeasurably, and this technic can replace the use of dangerous vaginal examination.

Radiation hazard in isotope localization is small compared to other diagnostic methods. The total irradiation to the fetus has been previously calculated as 70 milliroentgens allowing for total decay of the isotope, as well as for both beta and gamma radiation, versus 0.2 roentgen with a single x-ray film of the abdomen. Other radiographic localization methods usually require at least two exposures. Maternal radiation has been previously calculated to be 60 milliroentgens total body radiation, which is 25 per cent of the radiation received in I^{131} uptake studies,

and 5 per cent of the maximum tracer dose recommended by the Atomic Energy Commission.[8,10]

In addition to this safety factor, maternal ingestion of potassium iodide greatly reduces the uptake of radioactive iodine by the fetal or maternal thyroid. We have given a saturated solution of 10 drops of potassium iodide three times a day at least one day prior to the procedure to block thyroid uptake of I^{131}.[11] This is accomplished through the saturation of the maternal and fetal thyroid gland with non-radioactive iodine. As a result, counts run on the fetal cord blood show little or no radioactivity.[12]

The disadvantage of this method lies chiefly in that it requires special equipment, found only in radioisotope laboratories. However, there are no contraindications to the use of this test, save for active bleeding which requires immediate corrective action.

Summary

The importance of placental localization in the treatment of certain types of third trimester bleeding has been emphasized. A method of placental localization has been presented which immeasurably assists in the management of this distressing and potentially dangerous condition. The use of this method of placental localization enables a physician to accurately and rapidly obtain information essential to the correct management of third trimester bleeding. A series of 20 placentascans is reported, with an accuracy of 90 per cent for complete localization, and 100 per cent in predicting the presence or absence of low lying placenta.

Acknowledgment: Acknowledgment is given to the Isotope Laboratory at Saint Luke's Hospital, Cleveland, Ohio, to Clarence E. Everhart, M. D., to Miss Charlene Workman, R. N., and the members of the Obstetrics-Gynecology staff of St. Luke's Hospital for their assistance.

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A HOPEFUL EMOTIONAL ATTITUDE can actually prolong the life of a cancer patient. Patients who have hope of being well-remembered by family or friends or who have hope for an afterlife or some future existence live longer than non-hopeful and depressed patients. Hopelessness and depression actually speed the death of cancer patients. Patients with metastatic cancer, who died within two months after initial evaluation, had significantly lower hope for the future and even a future life than the group who lived longer. The patients with higher hope levels did not become depressed after intensive treatment. Those who become depressed immediately after treatment were the ones who died.

Some of these patients say, "I will be in heaven"; others say, "I will continue living through my children or through my work." The hopeful group realize they have cancer. They realize they are going to die. But they refuse to admit that death will end everything for them.

A patient's degree of hope or lack of hope is often conveyed to hospital personnel, and experienced ward personnel are often uncannily accurate in predicting the clinical course of individual cancer patients. — University of Cincinnati Medical Center News Release (April 10, 1966) of preliminary report by Louis A. Gottschalk, M. D., Research Professor, and Robert L. Kunkel, M. D., Instructor, Department of Psychiatry, University of Cincinnati College of Medicine.

Idiopathic Retroperitoneal Fibrosis

Report of a Case

WAI-MAN LEUNG, M. D., and CHARLES L. COGBILL, M. D.

IDIOPATHIC retroperitoneal fibrosis was first reported as a clinical entity by Ormond[1] in 1948, although Kay[2] cites several other earlier writers who described conditions which may well have represented this disease. In his 1963 article Kay[2] stated that he had found 125 cases in the world literature. On account of the rarity of reported cases it appears worthwhile to add a case recently seen by us. The etiology, pathology, clinical findings, and treatment of this condition will be discussed briefly.

Case Report

The patient was a 70 year old man admitted to the hospital October 18, 1964, complaining of abdominal pain, chills, and fever of 24 hours' duration. The pain was acute in onset, involved the entire right side of the abdomen, and radiated into the right flank. He had had intermittent, mild pain in the right side of his abdomen and lower back for about two years. During this time he complained also of weight loss, lethargy, anorexia, and constipation. Shortly before the onset of these symptoms he was hospitalized for the treatment of deep thrombophlebitis of the left leg and since that time had edema of both legs. There was a history of pulmonary tuberculosis 20 years before admission.

On physical examination, the temperature was 104°F, pulse rate 90 per minute and blood pressure 110/65. He appeared acutely ill and dehydrated. There was right upper and right lower quadrant abdominal tenderness and rebound. Both legs were edematous.

The hemoglobin was 15 Gm, hematocrit 46.5 per cent, and white blood cell count 23,700 with 91 per cent neutrophils. The urinalysis showed acid urine with specific gravity of 1.020; the urine contained no sugar nor albumin but was loaded with white blood cells. The VDRL was positive and the Wassermann reaction was plus 4. The blood urea nitrogen was 12 mg/100 ml. The serum electrolytes were normal except for a moderate hypochloremia. The sedimentation rate was 33 mm. per hour. Chest x-ray showed bilateral calcified foci in the upper lung fields, with no evidence of recent disease.

Two days after admission the patient became oliguric and the blood urea nitrogen rose to 56 mg./100 ml. Intravenous pyelography showed no visualization of the right kidney and faint visualization of the left. Retrograde pyelography showed complete obstruction of the right ureter low in the pelvis. There was narrowing and irregularity with partial obstruction of the left ureter (Fig. 1). A right nephrostomy was done with prompt improvement in the patient's condition and return of the blood urea nitrogen to normal levels.

On Dec. 8, 1964, transperitoneal exploration of the ureters was carried out. Both were encapsulated by grayish-white fibrous tissue at the sacral promontory; in this region, the iliac veins were also compressed by the same tissue. The ureters were so firmly encased in the surrounding fibrous-tissue mass they could not be freed and, at length, both were divided and end-to-end anastomoses performed. The left ureteropelvic junction was compressed by additional firm fibrous connective tissue but was dissected free without difficulty. Generous biopsies of the tissue obstructing the ureters were taken. The patient recovered from this operation without incident but within four months' time

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● **Dr. Cogbill, Dayton, is Chief, Surgical Service of the Dayton Veterans Administration Hospital, and Clinical Instructor in Surgery of The Ohio State University College of Medicine, Columbus.**

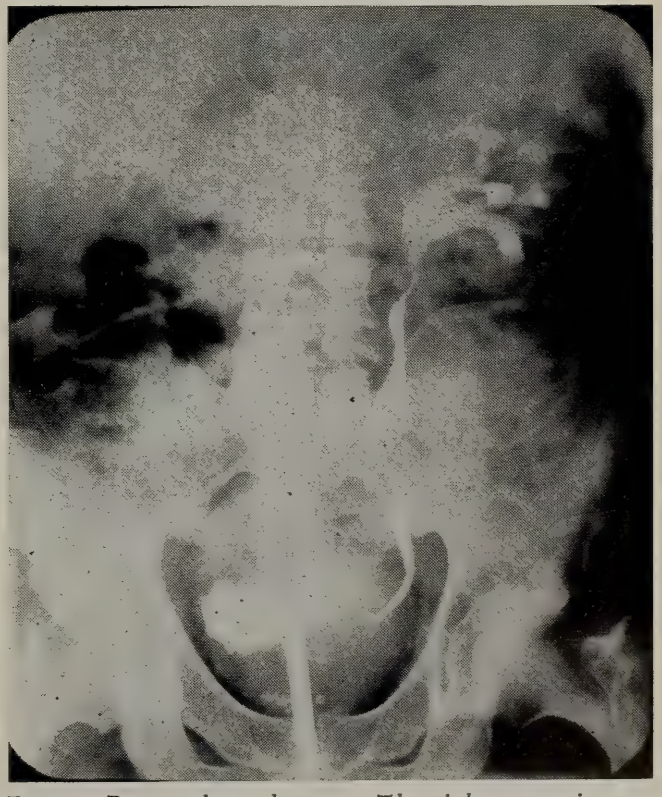


FIG. 1. *Retrograde pyelogram. The right ureter is completely blocked low in the pelvis. The left ureter is markedly narrowed at the ureteropelvic junction and lower down near the pelvic brim.*

both ureters became obstructed again and bilateral nephrostomies were performed. He has done well to the present time.

Microscopically, the tissue removed at operation was a lipogranuloma showing various stages of development. There was intense, dense collagen deposition with a few scattered granules of calcium. There were chronic inflammatory cells throughout (Figs. 2, 3 and 4).

Discussion

Etiology. The etiology of retroperitoneal fibrosis is poorly understood although a number of theories have been offered. Focal infection from the lower urinary tract or gastrointestinal tract with spread by lymphatic channels to the retroperitoneal space has been suggested by some.[3,4,5] Coppridge[6] postulated a relationship with Weber-Christian disease based on the finding of fat-filled macrophages and giant cells in the fibrotic tissue. Reidbord and Hawk[7] and Frazier and Small[8] felt that the pathologic picture suggested hyperallergic reaction and indicated that retroperitoneal fibrosis was related to polyarteritis nodosa and necrotizing arteritis.

Pathology. The envelopment of retroperitoneal structures by a grayish-white plaque of fibrous tissue is the basic disease process. A few cases have been reported in which the fibrosis involved also the extraperitoneal tissues of the anterior abdominal wall and and the mediastinum.[9,10] It is sometimes difficult grossly to distinguish this disease from retroperitoneal malignancy. Histologic features are nonspecific. Normal fibroblasts and collagen with chronic inflammatory cells are generally found. In some cases there

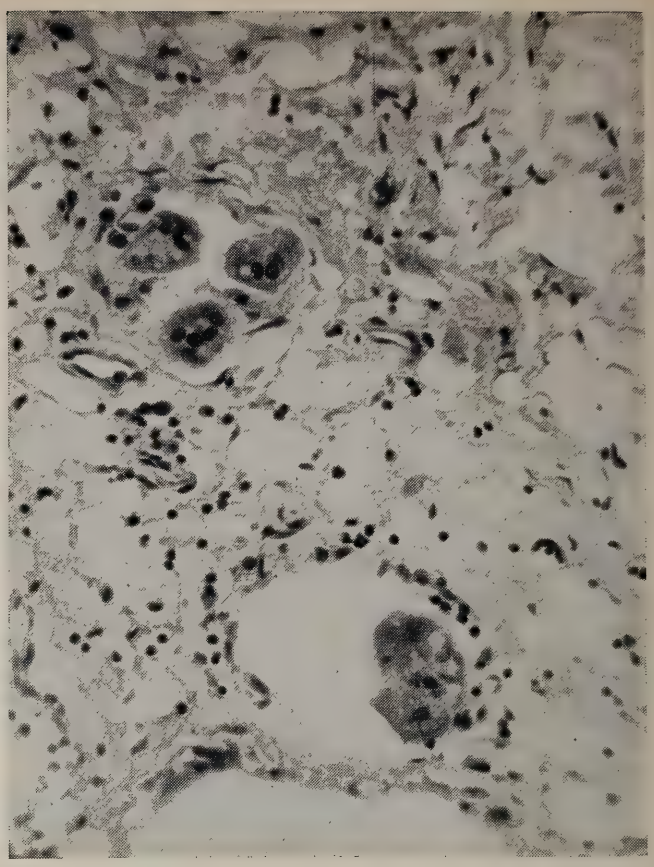


FIG. 3. *Photomicrograph showing granulomatous inflammation with multinucleated giant cells, lipid laden macrophagus, lymphocytes, and fibrosis.*

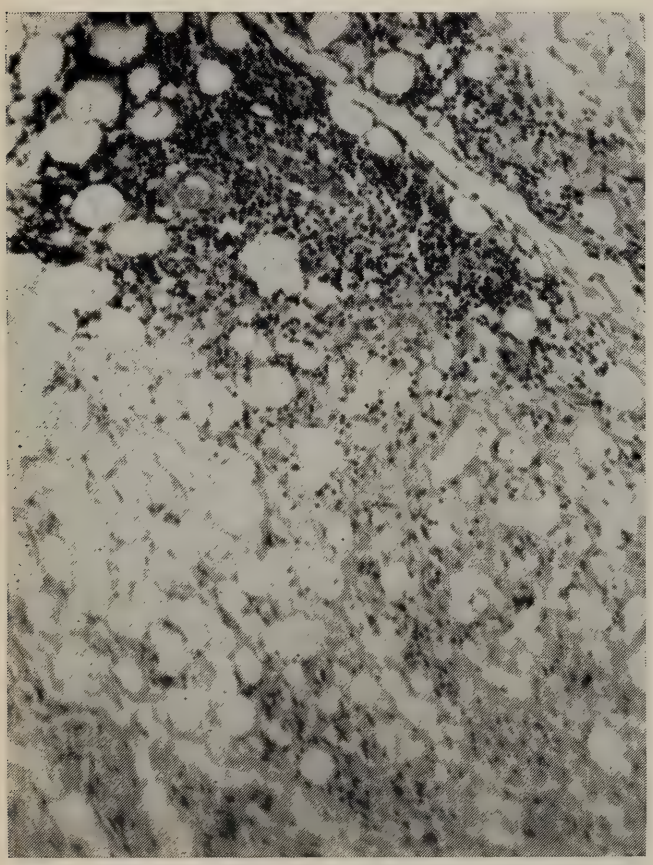


FIG. 2. *Photomicrograph showing fibrous connective tissue, chronic inflammatory cells and fatty infiltration — a lipogranuloma.*

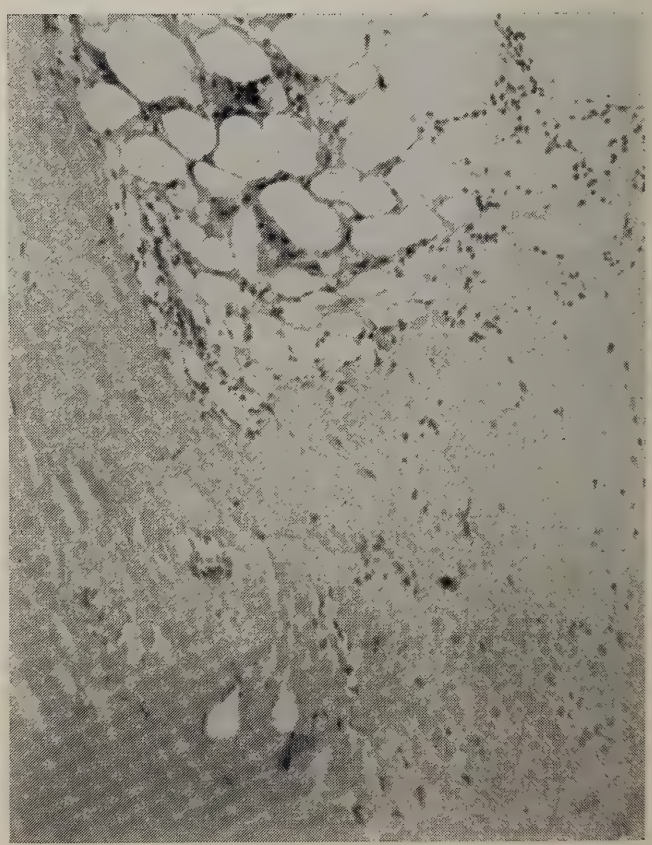


FIG. 4. *Photomicrograph showing dense collagenous connective tissue and adipose tissue.*

may be fat necrosis, granulomas with giant cells, or necrotizing vasculitis.

Clinical Findings. A majority of patients are within the fifth and sixth decades of life with a male to female ratio of 2:1. Early general symptoms and signs often are mild and nonspecific and may precede the appearance of acute symptoms by months or years. Obscure pain in the right and left lower abdomen and back, weight loss, fatigue, anorexia, eructation, and stomach distress with occasional nausea and vomiting may be present. There may be intermittent low-grade fever. Constipation and transient hematuria may occur. Some have reported chest pain, pericardial friction rub and pleural effusion.[2,9,11,12] Edema of the legs may occur. Oliguria and anuria occur late, as well as symptoms and signs of urinary tract infection. In general, symptoms and signs depend upon the organ or organ system that is compressed by the adjacent fibrous tissue.

Genitourinary Tract. Usually the first structures to be involved are the ureters. This may be manifested by chronic low-back pain and increased frequency of urination; a rather sudden onset of oliguria or anuria is not uncommon. Intravenous pyelography often reveals medial deviation of the ureters.[12,13] Retrograde pyelography is usually not difficult; the common site of obstruction is at the sacral promontory.

Vascular Involvement. The iliac veins commonly are compressed with resultant edema of the lower extremities. This was the situation in the present case. Obstruction of the vena cava has been reported in a number of cases.[11,14-16] Narrowing of the aorta by fibrous tissue compression has been reported by Furlong and Connerty,[17] intermittent claudication by Cameron et al,[11] and a case of gangrene of the foot by Croal.[18] Generally, however, the veins are the vessels which are obstructed, the arteries usually not being affected.

Laboratory Findings. Hypochromic microcytic anemia has been reported in 50 to 60 per cent of cases. The erythrocyte sedimentation rate is increased in most cases. Urinalysis may reveal normal urine or urine containing white blood cells. Depending upon the degree of ureteral obstruction, varying degrees of azotemia may be noted.

Diagnosis and Treatment. The diagnosis may be suspected from the symptomatology, especially the late symptoms of oliguria or anuria. Pyelography is useful in determining the site and degree of obstruction. The diagnosis can be established with certainty, however, only by exploration and biopsy. Ureteral obstruction usually can be relieved by ureterolysis and this is the procedure of choice. If this is not feasible other means of relieving the obstruction must be used, such as division of the ureter and anastomosis, ureteral-ileal transplants, cutaneous ureterostomy, or nephrostomy. X-ray therapy (Cameron et al[11]), and steroid therapy (Hawk and Hazard[9]) are reported to be useful but are difficult to evaluate. Surgery is indicated for the relief of obstruction. The disease is believed to be self-limited[2] and if ureteral obstruction is satisfactorily relieved patients may live for prolonged periods.

Summary

Retroperitoneal fibrosis is a rare disease of unknown etiology. It is characterized by masses of fibrous connective tissue encasing retroperitoneal structure, principally the veins and ureters. Ureteral obstruction is the commonest finding. Surgical relief of the obstruction is the only satisfactory treatment. If this is accomplished the mortality of the disease is low and the prognosis good for prolonged survival.

Acknowledgment: We wish to express our appreciation to Dr. Pauline Garber and to Dr. William H. Kirkham, Laboratory Service, of the Dayton Veterans Administration Hospital, for selecting and interpreting the photomicrographs.

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IT IS UNFORTUNATELY TRUE that the use made of an investigation depends more on the ease of performance than on the refinement of the result. — E. F. de Bono, M. D.: *British Medical Journal*, 2:1040, October 30, 1965.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

Presented by

- John E. Jesseph, M. D., Columbus, and
- Nils Ringertz, M. D., Karolinska Institute, Stockholm, Sweden.

Edited by Emmerich von Haam, M. D., Columbus.

PRESENTATION OF CASE

First Hospital Admission: A white man, aged 29, entered University Hospital for evaluation of hemoptysis. Four months before admission he noticed a postnasal discharge which persisted for a month. In the following three months he had intermittent episodes of hemoptysis which produced a teaspoonful of blood daily, a mild cough, and several episodes of fever and sweating. He had no weight loss or chest pain. A month before admission he became aware of dyspnea on exertion. This was progressive and at the time of admission he frequently had to rest during his work at a lead mold in a rubber factory.

The patient had smoked one and a half packages of cigarettes daily for several years but had stopped smoking at the onset of his illness, without significant change in symptoms. There was no family history of tuberculosis or of exposure to it. The past history and review of systems were not remarkable except for a one-month history of dark urine without irritative bladder symptoms.

On physical examination the patient was well-developed and well-nourished and in no acute distress. The temperature was 98.6°F., the pulse rate 82 per minute, the respiratory rate 18/min., and the blood pressure 150/80. There was no lymphadenopathy, no heart murmurs, no edema, and the lungs were clear to percussion and auscultation.

The laboratory examinations showed a hemoglobin of 9.1 Gm.; hematocrit 30 per cent; white blood cell count 8,345 with 68 per cent neutrophils, 22 per cent lymphocytes, 6 per cent eosinophils, 4 per cent monocytes. The urine was yellow and turbid; pH 5.0; specific gravity 1.003; protein 640 mg. per 100 ml.; there were rare coarsely granular casts, 2 to 5 white blood cells and many red blood cells per high power field. The serologic tests for syphilis were negative. Smear and culture of 24-hour sputum for acid-fast bacilli were negative; routine sputum culture yielded no growth of pathogens. A tuberculin skin test was negative.

A chest x-ray was interpreted as showing a slight decrease in the volume of the middle lobe with a few patches of bronchopneumonia. A bronchogram was interpreted as showing extrinsic pressure on the middle lobe bronchus, most probably caused by inflamed lymph nodes. There was associated spasm due to inflammatory changes. The middle lobe bronchial orifice was considered normal. No bronchiectasis or tumor was seen.

The patient was discharged to continue on ferrous gluconate therapy and to return in two months for a repeat bronchogram.

Second Hospital Admission

The patient remained at home for three weeks. His hemoptysis continued with the production of 1 tablespoon of blood daily. This had been streaks of blood mixed with sputum until the day before his second admission, at which time he coughed up a tablespoonful of bright red blood. In the three days prior to admission his chronic dyspnea worsened so that he was dyspneic at rest and unable to walk more than a few steps because of shortness of breath. He had noted blurring of his vision with each heart beat for two days. There had been occasional streaks of bright red blood on the toilet tissue. His urine had been dark during this interim period.

On physical examination the patient was alert, very pale, and dyspneic at rest. His pulse rate was

Submitted April 22, 1966.

110, respirations 40, temperature 98.2°F., and blood pressure 180/90. No significant lymphadenopathy was present. The chest was symmetric with no increase in anteroposterior diameter. Bilateral basilar rales and rhonchi were heard which were greater on the right. A grade II/VI systolic ejection murmur was heard at the apex of the heart. The pulmonic and aortic second sounds were equal. Examination of the abdomen, extremities, and nervous system revealed no abnormalities.

The laboratory examinations showed a hemoglobin of 4.5 Gm.; hematocrit 17 per cent; white blood cell count 14,800 with 75 per cent neutrophils, 19 per cent lymphocytes, 2 per cent basophils, 4 per cent monocytes. The urine had a pH of 5.0, specific gravity 1.003; protein 80 mg.; 0-1 waxy casts, rare coarsely granular casts, 3 to 5 white blood cells and 5 to 8 red blood cells per high power field. The blood urea nitrogen was 110 mg. per 100 ml. The serum iron was 43 mcg. per 100 ml., the iron binding capacity 413 mcg. A chest x-ray was interpreted as showing diffuse consolidation of the right lung, enlarged superior mediastinal lymph nodes, and splenomegaly. The over-all appearance suggested an unusual inflammatory process.

The patient was treated with intermittent positive pressure breathing, general supportive care, and transfusion of whole blood. The tachycardia continued. His respirations were rapid and shallow. Hemoptysis of bright red blood persisted, and a few hours after admission his blood pressure fell, he became cyanotic, and died.

CLINICAL DISCUSSION

DR. PASSI: We have the honor today of having as our pathological discussant Dr. Nils Ringertz, Professor of Pathology of the Karolinska Institute of Stockholm, Sweden. Dr. John Jesseph will present the clinical discussion.

DR. JESSEPH: I have no qualms about admitting at the outset that when I first read this protocol it was obvious to me that I didn't know what disease this was. It then followed by sheer logic that since I didn't recognize anything about the disease it must not be very common.

It is pretty clear that this young man, who was, we presume, entirely well until the onset of his illness, had some disease which was lethal within a total span of less than five months. It is pretty clear that over the entire period of his illness he never really got any better. There was a period before his second admission when he was probably clinically stable, but it is clear that he underwent no real remission.

His first admission was for hemoptysis which was of relatively sudden onset. This was accompanied by pulmonary infiltrates which were sort of evanescent. He had evidences of middle lobe syndrome with partial obstruction of the middle lobe bronchus. He had increasing dyspnea and this, actually, was probably his principal complaint along with hemoptysis. The dyspnea in this man was relentless. He just never was without shortness of breath once this disease began. He also developed hypertension of modest to mild degree and a fairly pronounced anemia, and then nephritis.

Renal Vein Thrombosis?

There are three or four disease processes loosely categorized with various names and descriptions which could explain all these symptoms. He had an acute lethal disease characterized by simultaneous involvement of the respiratory and the renal systems, with other features added. One acute process that could account for this might be renal vein thrombosis with a subsequent nephrotic syndrome and secondary pulmonary thrombo-embolism. In renal vein thrombosis, whatever the cause, there is a sudden flank pain associated with the thrombotic episode itself. These patients then have fever, leukocytosis, abdominal pain, and of course proteinuria with casts in the urine. In many instances secondary thrombo-embolism to the lung will lead to hemoptysis. In this particular patient, however, this would mean putting the process backward. We don't know that this man had an acute episode that might have been characterized as a renal vein thrombosis. He gave no history of trauma nor of any infectious process that would predispose to this, and we usually see this process most commonly in newborn infants, although it does occur spontaneously in young males.

The definite diagnosis of renal vein thrombosis would have to depend on a renal biopsy, and we have none in our present case. Renal biopsy in case of renal thrombosis would show after a suitable period of time tubular atrophy and other ischemic changes, as well as thickening of the basement membrane of the glomeruli. But we can only speculate. The rapidity and the extent of the occlusion in the renal vein, and whether or not it is unilateral or bilateral, will determine the nature of the process and will of course determine the prognosis. In adults this process usually comes as a consequence of thrombosis of the inferior vena cava secondary either to a traumatic or septic process in the extremities or pelvis. There was no history of that in our patient. So although we could reason logically that renal vein thrombosis with secondary pulmonary embolization might account for his symptoms, we would have to distort the history and we would have to assume certain things that are not presented in the protocol.

Wegener's Granulomatosis?

Another possibility is a syndrome which has been described as Wegener's granulomatosis, thought to be a variant of polyarteritis nodosa. Patients with this disease typically present initially pulmonary

lesions and widespread fibrinoid necrosis of blood vessels suggesting some sort of hypersensitivity phenomenon. The lesions can be found anywhere in the respiratory tract from the nares to the distal alveoli and are granulomatous processes with an early necrosis through fibrinoid necrosis and thrombosis of small arteries. This disease is commonest in men in their thirties and forties, so that while he is a little young for it, it might fit this patient. Hemoptysis occurs early in this process, the patient will have pleurisy, and the necrotic pulmonary lesions will form small cavities which will produce secondary hemoptysis. These patients typically fail to respond to antibiotics, with which they are usually treated on the presumption of some kind of viral or bacterial pneumonia. By the time multiple system involvement suggests a more generalized process, the patients are usually recognized as representing a variant of a collagen disease and are given steroids.

The course in this disease tends to be fulminant and the patients typically die within a few months from secondary pulmonary infection and/or uremia because of the necrotizing arteritis in the kidneys. It is said that in Wegener's granulomatosis the process tends to remit to some extent with steroids but the benefits from these are rather transient. Well, some things about this particular patient don't fit this diagnosis. I think that he did not have this much pulmonary difficulty. The course of his disease was not consistent with a progressive, relentless pulmonary process but rather suggested a granulomatous process, and the kidney changes were more pronounced in our patient than they are in typical Wegener's disease.

Strep Infection?

Hemolytic strep pneumonias with glomerulonephritis are a common kind of disease. This was particularly so in the pre-antibiotic days, but since I did not grow up in the pre-antibiotic days in medicine I can't certify this from personal experience. But we do know that patients with upper respiratory infection and pneumonia due to hemolytic streptococcus frequently develop these forms of acute glomerulonephritis, and I think that's seen even today to a certain extent. These changes are all part of an acute infectious disease typically limited in time, and the protocol describing our present patient is not consistent with acute respiratory infection secondary, or even primary, to hemolytic strep pneumonia and the kind of glomerulonephritis that would go with it. Rather, his disease ran a biphasic course. He was acutely ill with an evanescent pulmonary problem during which he had pulmonary changes which tended to remit somewhat. He really never had an acute febrile pneumonic process with consolidation of one or more segments of lobes. So clinically our patient just didn't have an acute pneumonia.

Pneumococcal Pneumonia?

The same thing can be said of pneumococcal pneumonia with acute renal failure. Transient proteinuria occurs sometimes in the course of pneumococcal pneumonia and it is possible in this infection, as it is in almost any infectious process, particularly the pulmonary ones, to have transient renal changes. Our patient's renal disease, however, was much more than transient. He had a significant lesion and yet it was not of the acute failure type; he did not have acute tubular necrosis and he did not really die in renal shutdown. The protocol rather suggested that although he had a significant renal lesion his death was pulmonary and his symptoms throughout his disease were predominantly pulmonary rather than renal.

Goodpasture's Syndrome?

There is another disease which seems to me to be a much more logical explanation for this patient's illness and that is Goodpasture's syndrome. In 1919 Dr. Goodpasture,[1] who was a pathologist at Boston, described some of his extensive experience with the influenza epidemic and became interested in the pathogenesis of certain forms of influenza and what could be deduced from the pulmonary changes about the nature of the causation of influenza. Dr. Goodpasture described two interesting patients, one of whom had a lesion much like our patient today, and since that time about 50 cases of this particular syndrome have been described in the literature. Dr. Goodpasture originally described a process with recurrent hemoptysis, dyspnea, some mild renal involvement, and eventual death in a man age 18. At autopsy, Dr. Goodpasture was nonplussed to find that despite very careful bacteriological studies he was able to isolate no organism whatever from this man's lung even though the lung itself was filled with hemorrhagic fluid and the alveolar spaces were lined by large macrophages containing debris and fibrin. Partially on the basis of this evidence, Dr. Goodpasture proposed that the primary etiologic agent in some of these peculiar processes in the lung might be an unknown virus which gained admittance to the respiratory tract through the respiratory passages.

But was Dr. Goodpasture really describing what we nowadays call Goodpasture's syndrome, which is my diagnosis in this case? I am not sure it is. Dr. Goodpasture described a man who was sick for about three months, much like our patient, who began with a pulmonary infection of a sort of nondescript nature and then had increasing hemoptysis, but nowhere, unfortunately, does Dr. Goodpasture give us a lot of detail about the findings in this man's urine. He was said to have a trace of albumin, but we really don't have any more evidence than that for nephritis. He would like to insist on cylindruria or some white casts in the urine, we would like to see an occasional red cell, and to satisfy the present-day criteria of

this disease I would like to find an increasing proteinuria. These things are entirely deleted from Dr. Goodpasture's description. Perhaps he was simply describing a patient with hemorrhagic viral pneumonia who had incidentally a touch of albuminuria which can accompany almost any disease from severe headache to a fractured leg.

Well, in this disease the whole process begins similarly to what we see in idiopathic pulmonary hemosiderosis; that is, there may be fever, chills, cough, easy fatigability, insidious development of anemia as hemoptysis persists, and then somewhere in the mid-course of the disease, which typically runs from one to six months and almost always less than a year, the patients develop nephritis and hypertension which is usually only mild to moderate. The serum iron in these patients is usually low, and the pulmonary sequestration of blood and blood breakdown products leads to alveolar plugging, hypertrophy of macrophages lining the alveoli, and typically these patients have increasing dyspnea which brings them to the hospital, as with our patient.

After following a relentless course that is rarely modified by any treatment, these patients die typically in pulmonary failure with the added complication of azotemia of a degree proportionate to the damage to the kidney. A study[2] of 69 patients with idiopathic pulmonary hemosiderosis showed that five had some renal lesions similar to what we see in this process described by Goodpasture. So it has been speculated that perhaps this disease is really a variant of idiopathic pulmonary hemosiderosis.

As I said at the beginning, this is not a surgical process, it certainly is not a very common one, and since I didn't know anything about it everything I have said today I have taken from the literature. It's clear to me that this patient couldn't have been considered a candidate for any operative therapy since there is nothing to take out from a patient with this disease. I think that this man was admitted with what appeared to be a partially obstructing process in the right middle lobe bronchus, which was simply a red herring.

DR. PASSI: May we now have a discussion of the radiologic findings in this case?

DR. HARRIS: As you correctly assumed, his first problem was in the right middle lobe. There was an infiltration of the right middle lobe and you see some mosaic findings in the lateral view suggesting that there may be loss of volume. For this reason a bronchogram was undertaken three days later, at which time we observed some incomplete filling of the right middle lobe. All of the right middle lobe main-stem bronchus was open. The films that really are of greatest interest were taken at the time the patient was readmitted. Here I believe you can see a consolidation throughout the major portion of the right lung, which would be consistent with some form of periarteritis or hemorrhagic pneumonia such as is seen in Goodpasture's. I do not believe I could make a specific diagnosis on the basis of these films, as this is not the classical appearance of Goodpasture's.

CLINICAL DIAGNOSIS

Goodpasture's syndrome: (a) pulmonary hemosiderosis; (b) glomerulonephritis.

PATHOLOGIC DIAGNOSIS

Goodpasture's snydrome: (a) pulmonary hemosiderosis; (b) glomerulonephritis.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: I would like to introduce my good friend Dr. Ringertz, who is Professor of Pathology at the Karolinska Institute in Stockholm. He was invited to give the Maud Abbott Memorial Lecture at the American Congress of Pathology, in which he discussed clear-cell carcinoma of the kidneys. Dr. Ringertz is particularly interested in tumors of the respiratory tract including the lungs, bronchi, trachea, and nasopharynx. He will discuss the pathological findings.

DR. RINGERTZ: I thank you very much, Dr. Haam, for your nice introduction, and I must say that you sprang a real stinker on me by giving me a case unlike any that I had ever seen before.

I think it is best to state at the beginning that Dr. Jesseph's suggestion of Goodpasture's syndrome was correct. I may say that the interesting autopsy findings are really restricted to two organs — the lungs and the kidneys. Everything else was rather unremarkable; for example, there were no evidences of generalized hemorrhagic diathesis, no petechiae in peritoneum, pericardium, pleura, skin or anywhere. Naturally there were enlarged lymph nodes in the mediastinum; you couldn't expect anything else with such severe lung changes. There were also some enlarged mesenteric and retroperitoneal nodes, and the spleen was about double normal weight — 350 Gm. — and appeared congested. The lungs weighed 1550 and 1350 Gm. The external surfaces had a bluish-gray appearance and the cut surface showed confluent nodular consolidations of deep purplish or blackish color. Both kidneys were enlarged and each weighed 300 Gm. The external surfaces were pale and the cut surfaces showed a thickened cortical zone and a markedly congested medulla.

The microscopic sections of the lungs showed most of the alveolar spaces filled with large macrophages containing brownish pigment. The interalveolar septa were thickened and contained many chronic inflammatory cells including deeply pigmented macrophages. Special stains proved that the brown pigment within the septa and the macrophages was iron. The cells resembled typical heart failure

cells but they were much more numerous and were present without evidence of chronic passive congestion.

Microscopic sections of the kidneys showed marked infiltration of the glomeruli with inflammatory cells, with numerous crescents in the Bowman's space. Special stain showed a marked thickening of the basal membranes of the affected glomeruli. The tubules contained hemoglobin casts and granular casts which gave a positive iron and PAS reaction. The microscopic picture of the mediastinal lymph nodes showed marked anthracosis and many iron-positive marcrophages. The histological examination of the remaining organs failed to give any evidence of systemic vascular disease.

The pathologic findings fully agree with the clinical diagnosis made by Dr. Jesseph — that of Goodpasture's snydrome, which he described in 1919 and which was re-introduced into the literature by the report of Stanton and Tange[3] in 1958. Several good reviews on the subject have been written recently and over a hundred cases have now appeared in the literature; unfortunately no case was available to me in Stockholm for study.

The disease has two components — the pulmonary and the renal. The lung disease consists of patchy intra-alveolar hemorrhage followed by fibrosis and mild inflammatory reactions. The amount of blood lost by hemoptysis is not indicative of the much larger amount of blood which is sequestered into the alveolar tissue, from which it cannot be successfully reabsorbed for re-utilization. This leads to a true iron deficiency anemia with corresponding response by the bone marrow. The accompanying renal lesion is that of glomerulonephritis which has many similarities to the renal lesion found in Wegener's granulomatosis.

Goodpasture's syndrome as it is known today belongs probably to the immune pathologic diseases which show some relationship to the group of collagen diseases. It has some similarity to idiopathic pulmonary hemosiderosis described many years ago by the German pathologist, Professor Ceelen.[4] The difference between the two conditions is more clinical than pathological since Ceelen's disease usually affects young individuals (children 1 to 6 years of age) and progresses more slowly, finally leading to death from pulmonary insufficiency or heart failure within three to six years. Another point of difference is the rarity with which renal complications are found in idiopathic pulmonary hemosiderosis.

General Discussion

DR. PASSI: This patient was admitted at the second time with an anemia of 4.5 Gm. This implies a considerable loss of blood since his previous hemoglobin determination, which was over 9 Gm. Dr. Jesseph, do you think this blood loss could be attributed to his hemoptysis or does it mean blood loss from other areas?

DR. JESSEPH: There is a remark in the protocol that he had just a touch of rectal bleeding, but we don't have any evidence that he was bleeding significantly from anywhere else. To answer your question more directly, it is conceivable to have this much anemia just from the hemoptysis. The blood is sequestered into the lung and only part of it is coughed up, and this process continuing for this long a time can produce this much anemia since the iron from the blood that is sequestered in the lung is lost for re-utilization.

DR. PASSI: The other factor which should be mentioned in the explanation of his anemia may be his splenomegaly found on his second admission. It is my understanding that large volumes of blood can be sequestered and lysed in the spleen.

The patient was bronchoscoped and I would like to ask Dr. Togut if one can make the differential diagnosis between Wegener's granulomatosis and Goodpasture's syndrome on bronchoscopy.

DR. TOGUT: I will admit that I don't know. If this process is confined to the alveoli or predominantly involves the alveoli, bronchoscopy could not give you the diagnosis. You might see blood in the bronchial tree, but I don't believe you could make the diagnosis by bronchoscopy. I wonder if we would have come close to a clinical diagnosis if we had examined the sputum and discovered the many macrophages containing iron. I also wonder if this could be a case of chronic lead poisoning.

DR. RINGERTZ: I cannot answer the last question, but I am certain that his sputum must have contained many so-called heart failure cells. The fact that they appeared in this patient who had no signs of heart failure might have been a clue to put one on the right track.

DR. VON HAAM: Thank you very much, Professor Ringertz.

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ATTENTION PROGRAM CHAIRMEN: We are most anxious to receive for consideration manuscripts, abstracts, or news items based upon lectures, symposia, etc., presented to Ohio physicians or those presented by Ohio physicians to other groups. — THE EDITOR.

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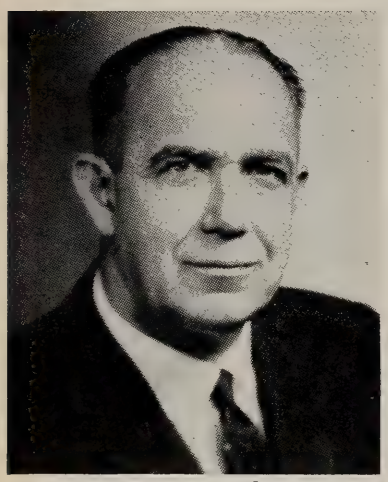
SEARLE *Research in the Service of Medicine*

Presenting Officers and Councilors Elected at the Annual Meeting

THE HOUSE OF DELEGATES of the Ohio State Medical Association named a President-Elect and two new Councilors at the 1966 Annual Meeting held in Cleveland, May 24-28, where the Incoming President was installed and several other members of The Council re-elected. Following are biographical sketches of these new officers with additional information on other members of The Council.

Dr. Robert E. Howard, of Cincinnati, was named President-Elect of the Association, and will assume the Presidency at the 1967 Annual Meeting in Columbus the week of May 14. He has served four years on The Council as Councilor of the First District. A practicing physician for some 35 years in Cincinnati, he specializes in otolaryngology.

Dr. Howard was born in Dayton and took part of his undergraduate training at Ohio Wesleyan University. Continuing his studies at the University of Cincinnati, he earned the A. B., B. S., and B. M. degrees, before he was awarded the M. D. degree from the College of Medicine in 1928. Postgraduate training included study tours at the University of Pennsylvania and the University of Vienna, as well as at Cincinnati General Hospital and the University of Cincinnati College of Medicine. Long a member of the faculty at the University of Cincinnati College of Medicine, he is now associate professor of otolaryngology, and lectures in otology and clinical anatomy of the head and neck. He is certified by the American Board of Otolaryngology and is on the staffs of nine Cincinnati hospitals.



Dr. Howard

Dr. Howard was first elected as Councilor of the First District in 1962 and was re-elected in 1964. He is a Past President of the Academy of Medicine of Cincinnati, and further served the Academy as Secretary-Treasurer and as member of the Board of Trustees. He also has been President of the Cincinnati Medical-Dental-Hospital Bureau, and the Cincinnati Speech and Hearing Center.

Before being named to The Council, Dr. Howard served in the House of Delegates, representing Hamilton County. Among additional services on the state level, he was chairman of the Auditing and Appropriations Committee of the Association and chairman of the Medical Advisory Committee to the Ohio State Society of Medical Assistants. The International Alpha Kappa Kappa Medical Fraternity recently named him as First Grand Vice-President.

Among other professional affiliations, he is a member of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology.

He has three sons and a daughter; and his wife Betty is a graduate nurse from Bethesda School of Nursing in Cincinnati.

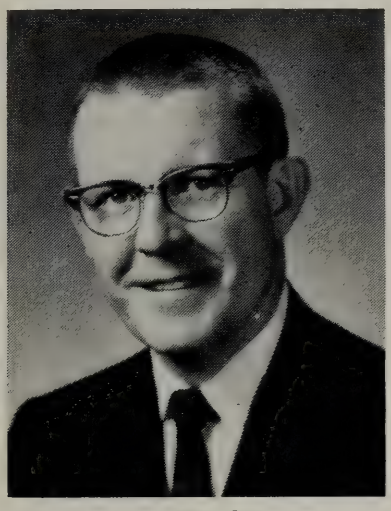
Incoming President Is Installed

Dr. Lawrence C. Meredith, of Oberlin and Elyria, was installed as President at the close of the 1966 Annual Meeting, and will serve in that office until the 1967 Annual Meeting in Columbus the week of May 14. He was named President-Elect at the 1965 Annual Meeting after serving five years on The Council as Councilor for the Eleventh District.

As President-Elect during the past year, Dr. Meredith has followed a busy schedule and has attended numerous functions in behalf of the medical profession. His travels on official busi-

ness have taken him from Philadelphia to Chicago, and to many other points outside of Ohio as well as in the State. In addition to functions of the State Association itself, he has attended numerous meetings of the OSMA Committees.

Long active in medical organization work, Dr. Meredith is a former secretary-treasurer of the Lorain County Medical Society and for



Dr. Meredith

many years was editor of the Society's newsletter. He was first elected to The Council, as Councilor of the Eleventh District, in 1960 and was twice re-elected to that office, being in the midst of his third term when named to the higher office.

Dr. Meredith took his undergraduate work at Oberlin College and at Ohio State University. The medical degree was received from Ohio State University College of Medicine in 1945, and internship followed at University Hospitals in Columbus. Fraternal affiliation is Alpha Kappa Kappa.

During World War II, he served in the Army Medical Corps and attained the rank of captain. Among assignments, he was post surgeon in Panama.

Residency training in otolaryngology was at University Hospitals in Cleveland. Since 1950 he has limited his practice to the ear, nose and throat specialty and in 1953 was made a Diplomate of the American Board of Otorhinolaryngology. In addition to his hospital appointments, he has served as secretary-treasurer, vice-president and president of the staff at Elyria Memorial Hospital.

In addition to his memberships in the local Medical Society and the State organization, he is a member of the American Medical Association, a Fellow of the American Academy of Ophthalmology and Otolaryngology, a member of the Ohio Committee on Trauma, member of the Cleveland Otolaryngological Club, the Cleveland Medical Library Association and the Elyria Chamber of Commerce; also the Congregational Church in Oberlin.

Dr. and Mrs. Meredith are the parents of two sons and a daughter.

First District Councilor

The House of Delegates elected Dr. Paul N. Ivins, of Hamilton, as Councilor of the First District to succeed Dr. Howard who was named President-Elect of the Association.

Dr. Ivins is a practicing physician in Hamilton and specializes in gastroenterology. Among activities in professional organization work, he has served as president of the Butler County Medical Society and the Hamilton Academy of Medicine, and has represented the Butler County Medical Society in the OSMA House of Delegates. Another position of responsibility in his professional work was that as chief-of-staff at the Fort Hamilton Hospital.



Dr. Ivins

Dr. Ivins was born in Hamilton and educated in the local schools. In 1931 he received an A. B. degree from Miami University at Oxford, and in 1934 earned his M. D. degree from Western Reserve University School of Medicine. An internship followed at the Methodist Hospital, Indianapolis, where he remained for residency training in pathology.

During World War II, Dr. Ivins served for 88 months of active duty with the U. S. Army, 24 months of that tour in the southwest Pacific area. He attained the rank of lieutenant colonel and for the last 18 months of his military tour was chief-of-laboratory service and pathologist at Wakeman Hospital Center.

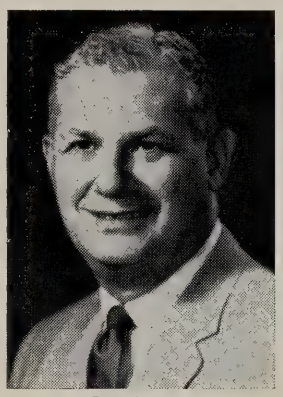
He resumed his practice in Hamilton in 1946. Among other activities, Dr. Ivins was chairman of the advisory council of the Hamilton Board of Health from 1951 to 1960, and was medical director of the Ohio Life Insurance Company from 1961 to 1966.

He is married to the former June Miller of Indianapolis. They make their home on a fruit farm which they operate as an avocation.

Seventh District Councilor

The House of Delegates elected Dr. Sanford Press, of Steubenville, as Councilor of the Seventh District, to succeed Dr. Benjamin C. Diefenbach, who had completed the maximum of three terms in that office.

Dr. Press was reared in Cleveland, attended the Cleveland public schools, and entered Western Reserve University for some of his undergraduate studies. He transferred to continue his studies at Ohio State University where he graduated in the summer of 1934.



Dr. Press

Being accepted at Wayne University Medical School, he went to Detroit and after graduating in 1938, took his internship at Harper Hospital, followed by a residency in obstetrics and gynecology at Woman's Hospital, Detroit.

In 1940, he began the general practice of medicine in Steubenville with a tendency toward the field of obstetrics and gynecology. With the events of World War II, he joined the U. S. Air Force in 1942 and served as flight surgeon in the China-India-Burma Theater, where he rose to the rank of major. In 1946, he returned to Steubenville to resume his practice.

Dr. Press is a member of the American Medical Association, Associate Member of the International College of Surgeons, member of the Academy of General Practice, and director for the Seventh District for the Ohio Academy of General Practice, as well as chairman of the program committee for the OAGP Annual Scientific Assembly in August of this year. He is president-elect for the 1966-1967 term of the Fort Steuben Academy of Medicine, an organization dedicated to promotion of postgraduate activities for physicians in the area.

At present, Dr. Press is an authorized examiner for the Pennsylvania Railroad and the Federal Aviation Agency. He is team physician for Steubenville "Big Red" High School, a position he has held with satisfaction for the past ten years. For 16 years he has been physician to the Jefferson County Home for the Aged.

He is a past president of the Lion's Club of Steubenville, is a member of the Elks Lodge, has held the position as president of his Synagogue for the last five years, and is a member of the Osiris Shrine and a 32nd Degree Mason.

His main hobby is photography, and he enjoys a good game of tennis. Dr. and Mrs. Press have two daughters — Susan, a student at the School of Pharmacy of the University of Cincinnati, and Sandy, who attends Steubenville High School.

Other Members of The Council

Dr. Henry A. Crawford, Cleveland, as Immediate Past President, will serve an additional year on The Council.

Dr. Frederick T. Merchant, Marion, was re-elected Councilor for the Third District. He was first elected to that office in 1964.

Dr. P. John Robechek, Cleveland, was re-elected Councilor of the Fifth District. He was first elected to that office in 1964.

Dr. George N. Spears, Ironton, was re-elected Councilor of the Ninth District. He was first elected to that office in 1964.

Dr. William R. Schultz, Wooster, was elected to his first full term as Councilor of the Eleventh District. He was elected in 1965 to fill one year of the unexpired term of Dr. Meredith who was named President-Elect at that time.

Councilors in the midst of two-year terms are Dr. Theodore L. Light, Dayton, Second District; Dr. Robert N. Smith, Toledo, Fourth District; Dr. Edwin R. Westbrook, Warren, Sixth District; Dr. Robert C. Beardsley, Zanesville, Eighth District; and Dr. Robert L. Fulton, Columbus, Tenth District.

Dr. Philip B. Hardymon, Columbus, is serving a three-year term as Treasurer.

Ohio State Heart Association Elects Officers for Year

Dr. George Morrice, Jr., Columbus, was elected President of the Ohio State Heart Association at its annual meeting in Cleveland on May 25. Mrs. Carl A. Strauss, Cincinnati, was re-elected to a second term as Chairman of the Board. Dr. A. P. Ormond, Akron, was re-elected Secretary, Newton D. Baker III., Cleveland, treasurer, and Raymond A. Brownsword, Akron, Assistant Treasurer.

Other physicians elected to the Executive Committee were: Dr. John A. Rogers, Youngstown; Dr. Sanford R. Courter, Cincinnati; Dr. J. Lester Kobacker, Toledo; Dr. Burton G. Must, Dayton; Dr. Jack S. Silberstein, Columbus, and Doctors Simon Koletsky and John W. Martin, Cleveland.

Proceedings of the House of Delegates 1966 Annual Meeting

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the Ohio State Medical Association was held in the Gold Room of the Sheraton-Cleveland Hotel, Cleveland, Tuesday evening, May 24. A dinner was held in the Whitehall Room preceding the business session.

The Reverend Frederick T. Schumacher, The First Church in Oberlin, offered the invocation.

Following the invocation, Dr. David Fishman, Cleveland, President of the Academy of Medicine of Cleveland and Cuyahoga County, welcomed the delegates to Cleveland and introduced President Henry A. Crawford, Cleveland, who delivered his presidential address. (See pages 718-722 for Dr. Crawford's address.)

Report on Delegates Present

The Credentials Committee reported 157 delegates seated and eligible to vote. A number of alternate-delegates, officers and executive secretaries of county medical societies were in attendance.

1965 Minutes Approved

The minutes of the 1965 sessions of the House of Delegates, as published in the July, 1965, issue of *The Ohio State Medical Journal,* **were approved** by official action.

Introduction of Honored Guests

Dr. Crawford introduced the following honored guests:

Dr. Seigle W. Parks, Charleston, West Virginia, president of the West Virginia State Medical Association; Dr. James S. Klumpp, Huntington, West Virginia, past-president of the West Virginia State Medical Association; Dr. Harold E. Barlow, Akron, president, Ohio State Dental Association; Mr. William Slabodnick, Norwalk; president-elect, Ohio Hospital Association; Mr. Eugene B. Imholt, Toledo, president-elect, Ohio State Pharmaceutical Association; Dr. Roger Grundish, Columbus, vice president, Ohio Veterinary Medical Association; Mrs. Marta L. Reeder, Ashland, president, Ohio State Nurses Association; Miss Sylvia Klotz, Toledo, president, Ohio State Society of Medical Assistants; Mrs. Frances Creamer, Dayton, past president, Ohio State Society of Medical Assistants; Mrs. Herbert F. Van Epps, Dover, president, Woman's Auxiliary to the Ohio State Medical Association; Mrs. James Wychgel, Cleveland, president-elect, Woman's Auxiliary to the Ohio State Medical Association.

OSMA Past Presidents Introduced

The following Past Presidents of the Association also were introduced: Dr. Edwin H. Artman, Chillicothe; Dr. Frank Mayfield, Cincinnati; Dr. Edward J. McCormick, Toledo; Dr. Horatio T. Pease, Wadsworth; Dr. George W. Petznick, Cleveland; Dr. L. Howard Schriver, Cincinnati; Dr. George A. Woodhouse, Miami Shores, Florida.

Also introduced were former members of The Council: Dr. Fred P. Berlin, Lima; Dr. George T. Harding, Columbus; Dr. George J. Schroer, Sidney.

Other guests introduced were: Dr. Hoyt D. Gardner, Louisville, Kentucky, member of the Board of Directors, American Medical Political Action Committee; Dr. Ralph K. Ramsayer, Canton, a member of the Ohio State Medical Board; Mr. Charles S. Nelson and Mr. George H. Saville, Columbus, former Executive Secretaries of the Ohio State Medical Association.

AMA-ERF Checks Presented

The following representatives of Ohio's medical schools were presented checks from the American Medical Association Medical Education and Research Foundation by President Crawford: Dr. Robert F. Parker, assistant dean, Western Reserve University School of Medicine; Dr. Robert M. Woolford, representing the University of Cincinnati College of Medicine; and Dr. John A. Prior, Associate Dean, Ohio State University College of Medicine.

AMA Certificates of Humanitarian Service

Certificates of humanitarian service were awarded to ten Ohio physicians for their service in South Vietnam by the American Medical Association. Present to receive their certificates were the following Ohio physicians: Dr. William Barratt, Painesville; Dr. C. W. Hullinger, Springfield; Dr. Alexander Miller, Cleveland Heights; Dr. Buel S. Smith, Akron and Dr. John E. Stephens, Columbus. Not present to receive the certificates were the following physicians: Dr. Frank Gatti, Portsmouth; Dr. Aaron Isaac Grollman, Cincinnati; Dr. Charles U. Hauser, Hamilton;

Dr. Hobart E. Klaaren, Dayton; Dr. Paul R. Miller, Columbus.

Ceremonies for Dr. Herbert M. Platter

Dr. Meredith was recognized and asked that the rules be suspended and that Resolution No. 1 honoring Dr. Herbert M. Platter be adopted. Resolution No. 1 **was adopted** by unanimous standing vote and acclamation. Dr. Meredith read the resolution, the text of which follows:

WHEREAS, Herbert Morris Platter, M. D., served the citizens of Ohio as Secretary of the State Medical Board of Ohio from 1917 through 1965, and has been a symbol of the purposes of this Association in promoting the science and art of medicine and the protection of public health, and

WHEREAS, Dr. Platter:

Conducted statewide investigations into epidemics of typhoid, scarlet fever and polio in 1908;

Established the first health program for the Columbus, Ohio, Public Schools in 1913;

Compiled the first Public Health Code for the State of Ohio in 1914;

Served as President of the Ohio State Medical Association in 1932-1933;

In 1964 was presented a Certificate of Merit by the American Medical Association for his initiation of the first scientific exhibit to be shown at an AMA Convention, held in Columbus in 1899;

Was awarded a certificate of appreciation by the President of the United States and was awarded a bronze plaque of recognition by the Federation of State Medical Boards of the United States in 1964, NOW THEREFORE BE IT

RESOLVED, that this 1966 Annual Meeting of the Ohio State Medical Association be dedicated to Herbert Morris Platter, M. D., in appreciation for his many years of service, as a physician and a citizen, to the people of Ohio, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association and the physicians of Ohio hereby express their admiration and gratitude to Dr. Platter for his outstanding leadership, guidance and counsel.

A copy of the resolution inscribed in bronze was presented to Dr. Platter along with a color television set.

Honors from the Governors

Lieutenant Governor John W. Brown presented Dr. Platter with a special message from Governor Rhodes, following which Lieutenant Governor Brown addressed the House paying tribute to Dr. Platter and recalling many incidents during which he and Dr. Platter had worked together during their careers in the service of the State of Ohio.

Report of Woman's Auxiliary President

At this time Mrs. Herbert F. Van Epps, Dover, President of the Woman's Auxiliary to the Ohio State Medical Association, was presented and gave a report on Auxiliary activities to the House of Delegates. (See pages 729-730 for the text of Mrs. Van Epps' address.)

Reference Committees Appointed

The following House of Delegates Reference Committees were reported by the President:

Credentials of Delegates—David Fishman, Cuyahoga County, Chairman; Chester J. Brian, Preble County; William Dorner, Jr., Summit County; Sol Maggied, Madison County.

President's Address — Joseph L. Bilton, Cuyahoga County, Chairman; Paul N. Ivins, Butler County; Edwin W. Burnes, Van Wert County; John R. Huston, Franklin County; William R. Graham, Huron County.

Resolutions Committee No. 1 — Frederick P. Osgood, Lucas County, Chairman; Carl A. Minning, Clermont County; Isador Miller, Champaign County; Dwight L. Becker, Allen County; Robert A. Irvin, Lake County; Charles W. Stertzbach, Mahoning County; Norman L. Wright, Coshocton County; Kenneth E. Bennett, Washington County; Richard E. Bullock, Vinton County; Jasper M. Hedges, Pickaway County; Charles H. McMullen, Ashland County.

Resolutions Committee No. 2 — John H. Budd, Cuyahoga County, Chairman; Robert M. Woolford, Hamilton County; Robert A. Bruce, Montgomery County; Donald R. Brumley, Hancock County; V. William Wagner, Ottawa County; Maurice F. Lieber, Stark County; Robert E. Rinderknecht, Tuscarawas County; James A. L. Toland, Guernsey County; William M. Singleton, Scioto County; Homer A. Anderson, Franklin County; Albert Burney Huff, Wayne County.

Resolutions Committee No. 3 — James C. McLarnan, Knox County, Chairman; Thomas E. Fox, Warren County; Maurice M. Kane, Darke County; Walter A. Daniel, Seneca County; William J. Neal, Fulton County; William F. Boukalik, Cuyahoga County; James W. Parks, Summit County; James F. Sutherland, Belmont County; Carl E. Spragg, Muskingum County; Roger P. Daniels, Meigs County; Ben V. Myers, Lorain County.

Tellers and Judges of Election — James G. Tye, Montgomery County, Chairman; Daniel V. Jones, Hamilton County; Robert S. Oyer, Auglaize County; Shepard A. Burroughs, Ashtabula County; Leonard V. Phillips, Summit County; Sanford Press, Jefferson County; Jay Ross Wells, Licking County; Thomas W. Morgan, Gallia County; Joseph A. Bonta, Franklin County; Emil J. Meckstroth, Erie County.

Nominating Committee Elected

The next order of business was the election of a Nominating Committee. The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District — Daniel V. Jones, Hamilton County.

Second District — George J. Schroer, Shelby County.

Third District — Fred P. Berlin, Allen County.

Fourth District — Edwin C. Winzeler, Henry County.

Fifth District — Paul A. Mielcarek, Cuyahoga County.

Sixth District — Edward A. Webb, Portage County.

Seventh District — Elias R. Freeman, Harrison County.

Eighth District — Kenneth E. Bennett, Washington County.

Ninth District — Thomas W. Morgan, Gallia County.

Tenth District — Lewis W. Coppel, Ross County.

Eleventh District — William R. Graham, Huron County.

Dr. Crawford then announced that under a system of rotation approved by the House of Delegates in 1963, chairman of the committee for this year would be the nominee from the Fourth District, Dr. Edwin C. Winzeler, Henry County.

Introduction of Resolutions

Dr. Crawford then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting should be read by title only for referral. Forty-three resolutions were read by title only and referred to the resolutions committees.

New Resolutions Presented

Dr. Crawford then called for the presentation of new resolutions. He ruled that any delegate wishing to present a resolution not submitted 60 days before the meeting should explain the purpose of the resolution and why it could not have been submitted in advance. He announced that such resolutions then could be received upon consent of two-thirds of the delegates present. The following resolutions were then submitted. They were accepted by the House of Delegates and were referred to the Resolutions Committees.

RESOLUTION NO. 45

Subscribers to Part B of Medicare Are Entitled To Treatment as Private Patients

(By the Academy of Medicine of Cleveland)

WHEREAS, the "Modification of Proposed Third Principle Payment for Services Involving Residents and Interns, "as embodied in Part B of the Medicare Law, states, as follows:

"In the case of Major Surgical Procedures, as defined by the Joint Commission on Accreditation of Hospitals, and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician," and

WHEREAS, since this principle is designed to safeguard that high caliber of professional care which the profession is committed to provide, and

WHEREAS, The American College of Surgeons Committee on Medicare has proposed modification of this principle in such manner that the patients, for whom payment will be made under Title #18 of the Medicare Law, would, in many institutions, be placed under the "complete responsibility" of interns and residents in training, and that this further connotes lack of personal supervision by the attending physician, and

WHEREAS, such a modification would approve a procedure wherein a physician would receive compensation for services which he did not personally provide to the patient, and

WHEREAS, such receipt of compensation would be both unethical and dishonest, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association hereby records itself in support of the principle that subscribers to Part B of Medicare, by payment of premium, have purchased the same rights to personal medical care enjoyed by any other private patient, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association hereby records itself in support of the principle that professional responsibility of a physician, for services rendered by an intern or resident implies personal supervision and direction, in order to be considered identifiable and compensable service, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association instruct its Delegation to the American Medical Association to present this Resolution at the annual meeting of June 26-30, 1966, seeking its adoption, AND BE IT FURTHER

RESOLVED, that a copy of this Resolution be forwarded to the Secretary of The Department of Health, Education, and Welfare.

RESOLUTION NO. 46

Compliance with the Civil Rights Act of 1964

(The Second Councilor District)

All Physicians, as citizens of the United States, are bound by the laws of the United States. There is no need to demean them by asking an oath of compliance to those laws and their regulations. Especially not for the receipt of remuneration for services rendered to welfare recipients.

The Ohio Department of Welfare has again notified physicians of Ohio that, "We regret very much that we are not in a position to pay the enclosed bills without the assurance of compliance with the Civil Rights Act of 1964 as required by federal law and regulations."

In October 1965 the House of Delegates of the American Medical Association passed a resolution stating that the House of Delegates directs the Board of Trustees and the Officers of this Association to oppose actively and forcefully this and any future attempts by HEW or any other federal agency to impose conditions and pledges upon the medical profession. THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association petition the Board of Trustees and the Officers of the American Medical Association to actively and forcefully oppose the requirement of the federal law and regulations that ask assurance of compliance with the Civil Rights Act of 1964 from individual citizens, even through the Supreme Court.

One Resolution Inadvertently Omitted

A resolution on reimbursement to county medical societies for costs of collection of OSMA and AMA dues was inadvertently omitted from the printed resolutions. The President ruled that it was in order for such resolution, therefore, to be considered by the House and it was assigned to Resolutions Committee No. 1 and numbered Resolution No. 47.

RESOLUTION NO. 47

Reimbursement of Costs for Collection of Dues

(By Academy of Medicine of Cincinnati)

WHEREAS, the Ohio State Medical Association and the American Medical Association have increased the demands on local County Medical Societies for additional services; and

WHEREAS, the increase in demands by Ohio State Medical

Association and the American Medical Association through extended programs require additional expenditures by County Medical Societies; THEREFORE, BE IT

RESOLVED, that the County Medical Society be reimbursed for costs expended in the collection of dues and the certification of membership to both the Ohio State Medical Association and the American Medical Association.

Following announcements about meetings of the reference committees and the second session of the House of Delegates, the House recessed until Friday morning, May 27.

MINUTES OF SECOND SESSION

The second session of the House of Delegates of the Ohio State Medical Association at the 1966 Annual Meeting was held on Friday morning, May 27, in the Gold Room, Mezzanine Floor of the Sheraton-Cleveland Hotel.

The meeting was called to order by President Crawford. He introduced the following guests who addressed the House: Dr. William B. West, Huntingdon, Pennsylvania, president of the Pennsylvania Medical Society; Dr. Donald K. Dudderar, Newport, Kentucky, vice president of the Kentucky Medical Association; Dr. Seigle W. Parks, Charleston, West Virginia, president of the West Virginia State Medical Association; Dr. Luther R. Leader, Royal Oak, Michigan, president of the Michigan State Medical Society. Also introduced were Dr. Kenneth O. Neumann, Lafayette, Indiana, president of the Indiana State Medical Association; Dr. James S. Klumpp, Huntington, West Virginia, past president of the West Virginia State Medical Association; Dr. Thomas L. Dwyer, Mexico, Missouri, president of American Association of Physicians and Surgeons; Dr. Wm. P. Smith, Jr., Columbus, president, Ohio Academy of General Practice; Dr. Carl A. Lincke, Carrollton and Dr. George W. Petznick, Cleveland, Past Presidents of the Association. Messrs. Joel Ginsberg, R. Dennis Blose and Frederick Mueller, representatives of the Student AMA Chapter, Ohio State University.

Dr. David Fishman, Cuyahoga County, Chairman of the Committee on Credentials of Delegates, reported that 151 delegates were seated and eligible to vote. Also present were alternate-delegates, officers and other guests.

Committee on President's Address

President Crawford called for a report of the Reference Committee on the President's Address, which was presented by Dr. Joseph L. Bilton, Cleveland, delegate from Cuyahoga County and chairman of the committee. It read as follows:

"Your Committee on the President's Address first wishes to commend our President who took the reins of our organization at a critical time when the "ax was about to fall" and vowed he would not preside over a wake. Throughout his speech he has indicated an aggressive policy, with apologies to no one. It is our impression that, with the aid of all parties concerned, we are coming out of a very difficult situation with the best possible advantage. We are particularly proud of this aggressive and non-apologetic approach in that we feel that no apology is due from a profession that has performed as well as our's over the years.

"President Crawford has pointed out our multiple activities and, indeed, our leadership, not only in professional matters, but in the socio-economic and legislative problems that have beset our profession in recent years. In connection with this topic, he commends our leadership and our Association, for the foresight, imagination and courage in initiating and pursuing the "USUAL AND CUSTOMARY FEE" schedule, first, with the O.M.I. and, next, with the Ohio Bureau of Workmen's Compensation. As Dr. Crawford has indicated, he hopes that we will be honest, fair and cooperative in the pursuit of these gains so that we do not lose the advantage of the usual and customary fee schedules which it is hoped will grow to include all negotiations where third party payments are concerned.

"A major theme running through much of our President's address stressed the preservation of physician-patient relationship. He urged us to pursue this relationship in all matters concerning our profession.

"Again, our President reiterated our policy of support to all elements of the medical profession in our effort to remain free and unfettered in relationship with our patients, to help repel third party control, and to assist all those who are not now free to gain this status.

"Throughout his speech, we discern certain pride in the activities, accomplishments and dynamism of our leadership. He notes the increased and intelligent interest of our delegates, our councilors, state officials and AMA delegates. Particularly, we share his pleasure in the accomplishment and special credits that accrue to such members of our delegation as Drs. John Budd, Charles Hudson, and others who have placed Ohio in the forefront of the national medical scene, but, more importantly, have exercised a determined leadership that has helped direct our profession through these critical times.

"Dr. Crawford states, and we are inclined to agree, that the main theme of his speech is the "new look" and here we quote: 'The atmosphere in which we practice is taking on a new look. We must adjust . . . we must adapt . . . and we must dedicate ourselves to the task of meeting this new look, the new conditions and responsibilities that confront us.'

"There is no doubt that we must change our thinking in many areas. Many of our older concepts, once revered, now appear as out of place as a double-breasted suit in this 'jet' age. But more than ever, as our President points out, we must assume our responsibilities in conducting our affairs, promoting our image and maintaining a high caliber of medical practice. We can no longer afford to 'let George do

it' for today, 'George' is Blue Cross, the Federal Government, Hospital Council and many other organizations who are not only too willing to do it for us but are also eager to tell us how to do it. He points out that we, therefore, must accept the fact that we are going to be subject to some controls. We now have an opportunity to control ourselves, or we have the alternative of having controls imposed upon us by outsiders, perhaps not unlike those being imposed upon the drug industry today.

"With a loud Amen, we commend his reference to the Medical Practice Act.

"Strongly emphasized was our need to keep ourselves aware of the socio-economic changes in medical practice as they occur from week to week or month to month, and the steps our Association is taking to counter or implement these changes as our judgment dictates. We noted our President's rather petulant mood in chastising us for failing to keep ourselves informed and supporting the leadership. We can assure him that at least the members of this Committee have read Newsletter No. 3.

"Regarding post graduate education, he points out that the tide of medical information is overwhelming and surpasses what we can pick up with random meetings. He implies that perhaps some organized post graduate study should be considered and sponsored by our profession.

"Finally, will there be light, or will there be darkness? Will we complain about the darkness or light a candle? We believe our President has 'lighted the candle' so that we may all see our way. He has urged us to enter actively into not only medical affairs but in community activities, into socio-economic affairs of our community, to re-establish and improve the image of the 'M. D.' as a community force.

"Mr. President, I move the adoption of this report.

"I wish to thank the members of my Committee for their careful study and evaluation of an outstanding address by an outstanding President of this Association. They are: Paul N. Ivins, Butler County; Edwin W. Burnes, Van Wert County; John R. Huston, Franklin County; William R. Graham, Huron County; Joseph L. Bilton, Cuyahoga County, Chairman."

On motion made and seconded, the House of Delegates by official action approved the report of the Committee on the President's Address.

Dr. Annis Introduced

At this time Dr. Edward R. Annis, Miami, Florida, a past president of the American Medical Association, was introduced and he received a standing ovation by the members of the House. Dr. Annis asked for renewed purpose and direction on the part of a profession that will not be subjugated by direction from any source. He called for determination that this country continue to have an independent medical profession in a free society.

Report of Resolutions Committee No. 1

Dr. Frederick P. Osgood, Lucas County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"I have the privilege of presenting to the House of Delegates the following report of Resolutions Committee No. 1. The committee had 16 resolutions for consideration, including one emergency resolution introduced on the floor of the House, by consent of two-thirds of the delegates.

RESOLUTION NO. 2

Dues Exemption for Financial Emergencies

(By The Council of the Ohio State Medical Association)

WHEREAS, Amended Resolution No. 8, as adopted by the 1965 OSMA House of Delegates, has directed that an appropriate amendment regarding dues exemption for financial emergencies be prepared by the legal counsel, under the supervision of The Council of the Ohio State Medical Association, for submission to the 1966 OSMA House of Delegates, the following resolution is offered in compliance therewith: THEREFORE BE IT

RESOLVED, that Section 1 of Chapter 2 of the By-Laws of this Association be amended and supplemented by adding at the end thereof the following paragraph:

> A member of this Association for whom payment of his regular dues in this Association constitutes a financial hardship may request The Council of this Association for an adjustment of dues. Such request shall be in writing, signed by such member and filed with the secretary of such member's local medical society. If the society, or the council of the society, finds that payment by such member of his regular dues in this Association shall constitute a financial hardship and certifies such finding to The Council of this Association, The Council will make such adjustment of his OSMA dues for such period of time, and subject to such conditions, as The Council may deem appropriate and advisable.

"The first resolution considered by the committee was submitted by The Council of the Ohio State Medical Association. This resolution was reviewed thoroughly. Many of the delegates spoke to the resolution favorably. It was the consensus that this resolution be adopted as introduced and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 2 be adopted as introduced, was approved.

RESOLUTIONS NO. 3, NO. 4, NO. 5, NO. 6

Mental Health

"Resolution No. 3 entitled 'Mental Health Legislation,' submitted by The Council of the Ohio State Medical Association; Resolution No. 4 entitled 'For Reorganization of Ohio State Mental Health Activities,' submitted by the Academy of Medicine of Cleveland; Resolution No. 5 entitled 'Policy Statement on Services to the Mentally Ill,' submitted by the delegates of the Summit County Medical Society; and Resolution No. 6 entitled 'Admissions of Mentally Retarded Children' and submitted by the Put-

nam County Medical Society, were considered together.

"The content in each of the first three resolutions was directed essentially at the same objective. We were indeed fortunate to have the very wise counsel of many very knowledgeable members.

"Your committee wishes to submit a composite resolution in lieu of Resolutions 3, 4 and 5, as follows:

SUBSTITUTE RESOLUTION ON MENTAL HEALTH

WHEREAS, Ohio State facilities for treatment of mental illnesses are supervised by a Director of Mental Hygiene and Correction who also oversees the penal system, thus linking the mentally ill and criminals under one system to the detriment of both, it is believed that creation of a separate Department for Mental Health would be a major step toward providing more nearly adequate facilities for this State of Ohio. THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association take steps to initiate and to support in the next session of the Ohio Legislature, legislation which will

(1) Create a separate Department of Mental Health and Retardation in the State of Ohio;

(2) Establish a position of 'Director of Mental Health' with cabinet status *who, if possible, would be a doctor of medicine;* and

(3) Establish a Board of Mental Health composed of 5 to 7 members appointed by the Governor, who shall serve overlapping terms. At least four members shall be doctors of medicine of recognized competence in the care of the mentally ill and retarded, AND BE IT FURTHER

RESOLVED, that said Board of Mental Health shall have the following functions:

(1) Advise and assist in the establishment and implementation of policies for the Department of Mental Health.

(2) Recommend to the Governor candidates for the position of Director of the Department of Mental Health.

(3) Meet several times yearly to consider all matters pertinent to effective function of the Department of Mental Health.

(4) Submit to the Governor annual reports which shall be made public, AND BE IT FURTHER

RESOLVED, that the House of Delegates direct the Association's Committee on Mental Health to develop separate legislation calling for statutory autonomy for mental retardation within the Department of Mental Health, AND BE IT FURTHER

RESOLVED, that the principles developed above be the official policy of the Ohio State Medical Association. However, the desirability of OSMA sponsorship of such legislation in the 107th General Assembly shall be determined by The Council, AND BE IT FURTHER

RESOLVED, that efforts be directed toward the adoption of a Community Mental Health Services Act which places in the local community the responsibility for specific treatment programs.

"Mr. President, I move the adoption of the Substitute Resolution on Mental Health."

By official action the recommendation of the committee, namely, that the Substitute Resolution on Mental Health be adopted, was approved with an amendment from the floor which is indicated by the words in Italics.

(For text of Resolutions 3, 4, 5, see pages 481, 482, May, 1966 issue OSMJ.)

RESOLUTION NO. 6
Admissions of Mentally Retarded Children

"Resolution No. 6 was submitted by the Putnam County Medical Society. On the basis of the action of the committee relative to the previous resolution, it was felt that the problem presented in Resolution No. 6 could be properly and adequately handled by the resultant organizational setup. For this reason, I move that Resolution No. 6 be **not** adopted and, Mr. President, I so move."

By official action the recommendation of the committee, namely, that Resolution No. 6 NOT be adopted, was approved.

(For text of Resolution No. 6 see page 482, May, 1966 issue OSMJ.)

RESOLUTION NO. 24 AND RESOLUTION NO. 41
Claims Form

"Consideration was next given to Resolution No. 24 entitled 'Standardized Claims Form,' introduced by the Mahoning County Medical Society, and Resolution No. 41 entitled 'Regarding "forms" for Participants of Part B of Medicare,' introduced by the Huron County Medical Society.

"There are at the present time forms available which are, we are advised, in the process of revision. The committee was in complete accord with an attempt to simplify and standardize forms for third party payments. Inasmuch as Resolution No. 24 encompasses the import of Resolution No. 41 and permits a much wider use, the committee recommends that Resolution No. 41 be **not** adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 41 NOT be adopted, was approved.

(For text of Resolution No. 41 see pages 490 and 491, May, 1966 issue OSMJ.)

"The committee recommends that Resolution No. 24 be amended as follows: In the second line of the first RESOLVE in the place of the words 'to be used' insert 'which may be used,' and delete the words 'the Department of HEW or its.' Mr. President, I move the adoption of Amended Resolution No. 24, which reads as follows:

AMENDED RESOLUTION NO. 24
Standardized Claims Form

WHEREAS, under Public Law 89-97 (Medicare) a claims form has been proposed by the Department of Health, Education, and Welfare for the implementation of Part B of the Act, and

WHEREAS, the completion of such form together with the physicians' signature, may establish precedence with reference to future and even more objectionable forms, and

WHEREAS, it is reasonable to provide essential medical information for the purpose of reimbursement, and

WHEREAS, a standardized claims form is desirable for all third party claims, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association adopt a standardized claims form which may be used in lieu of

any proposed form submitted by a fiscal intermediary, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association make available to all its members who desire to use it, a claims form similar to the one submitted in the printed resolutions (quod vide) modified as necessary by the presently acting committee.

By official action of the House, the recommendation of the committee, namely, that Amended Resolution No. 24 be adopted, was approved.

(For text of Resolution No. 24 see page 486, May, 1966 issue OSMJ.)

The resolution as approved reads as follows:

RESOLUTION NO. 39
To Upgrade the Education of the Deaf and Hard of Hearing

"Resolution No. 39, introduced by the Fourth District Councilor, was considered in great detail. The experts who spoke to this resolution were desirous of having the word 'deaf' changed to 'hearing handicapped.' With this suggestion in mind, it is recommended that in all places where the word 'deaf' is used it be changed to read 'hearing handicapped' and that the second RESOLVE read as follows:

'RESOLVED, that the Council of the Ohio State Medical Association promote a broad public educational program beamed through the Parent-Teacher Associations, Mothers' clubs, Child Conservation Leagues and civic organizations for the purpose of urging an improvement in the education of the hearing handicapped in the State of Ohio.'

"Mr. President, I move the adoption of the editorially changed Resolution No. 39."

By official action, the recommendation of the committee, namely, that editorially changed Resolution No. 39 be adopted, was approved.

EDITORIALLY CHANGED RESOLUTION NO. 39
To Upgrade the Education of the Hearing Handicapped
(By the Fourth District Councilor, Robert N. Smith, M. D., Toledo)

WHEREAS, the problems of the hearing handicapped are founded in the loss of auditory communication, and

WHEREAS, these problems can be largely overcome by proper special education, and

WHEREAS, in the 1963 research of the Division of Special Education of the State of Ohio it was estimated that one child in every 20 in school or at the preschool level had a significant hearing loss, and

WHEREAS, only fifteen per cent of today's young people with hearing handicaps successfully complete the full scale high school academic program, and

WHEREAS, the hearing handicapped are conceded to have potentially normal intelligence when tested by standardized nonverbal tests, and

WHEREAS, it is the duty of the physician to promote rehabilitation when he cannot cure; THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association urge that the State Board of Eduation be instructed by the Governor to upgrade education of the hearing handicapped in the State of Ohio

(a) by promoting oral education of the hearing handicapped child in contrast to the manual method;

(b) by providing more educational facilities, properly staffed and equipped, with a goal of one special education unit for the hearing handicapped per county, or small group of counties;

(c) by integrating these special education units with regular elementary and high school facilities, where possible;

(d) by constantly recruiting young people to enter the field of education of the hearing handicapped as a profession, and

(e) by seeking adequate funds from the legislature to support a proper program; AND BE IT FURTHER

RESOLVED, that the Council of the Ohio State Medical Association promote a broad public educational program beamed through the Parent-Teacher Associations, Mothers' clubs, Child Conservation Leagues and civic organizations for the purpose of urging an improvement in the education of the hearing handicapped in the State of Ohio; AND BE IT FURTHER

RESOLVED, that all physicians, especially those in general practice and the specialities of pediatrics and ear, nose and throat, be adequately prepared to advise their patients as to the scientific techniques and special educational facilities which are available for the education and rehabilitation of the hearing handicapped child or adult.

RESOLUTION NO. 26
Changes in Certificate of Live Birth

"Resolution No. 26 was submitted by the Montgomery County Medical Society.

"The discussion that was heard relative to this resolution developed the fact that the birth certificate is a legal document and, as such, is open to public scrutiny. It was pointed out that the birth certificate is not intended as a statistical survey. For these reasons the committee recommends that Resolution No. 26 be not adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 26 be NOT adopted, was approved.

(For text of Resolution No. 26 see page 486, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 29
Training More General Practitioners

"The committee next considered Resolution No. 29, submitted by the Huron County Medical Society. There was a lively discussion from the floor and letters were introduced from the dean of the Ohio State University College of Medicine and written comments from the Department of Preventive Medicine of Ohio State University.

"The committee felt that the intent of the resolution was quite in accord with the expression of opinion of the OSMA House of Delegates for many years past, but that there had been no useful purpose served by the introduction of personalities. For this reason a substitute resolution is presented which reads as follows:

SUBSTITUTE RESOLUTION NO. 29
Training More General Practitioners

WHEREAS, it is a statistical fact that Ohio communities request family physicians (OSMA Physicians' Placement Service) 15 times more often than specialists, and

WHEREAS, it would be a realistic and functional responsibilty of the medical schools in the State of Ohio, in a democratic spirit of supply and demand free enterprise system, to meet the demands (needs) of the citizens of Ohio pertinent to a need of more family physicians; THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association express most sincere thanks as a

token of gratitude to the Joint Committee of the Ohio State Medical Association — Ohio Academy of General Practice for their untiring efforts to bring about the fulfillment of the most realistic, dire, and critical need for an increase in the numbers of family physicians in the State of Ohio — and even nationally; BE IT FURTHER

RESOLVED, that the suggestions of this resolution be acted upon swiftly and commensurate with the acute and dire critical need for more family physicians, both Statewide and nationally. The latter action to be taken wholeheartedly, most diligently, and most sincerely by the various deans of the medical schools in the State of Ohio as a fulfillment of their responsibilities as medical leaders, as has been voiced by the President of the American Medical Association.

"Mr. President, I move the adoption of Substitute Resolution No. 29."

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 29 be adopted, was approved.

(For text of Resolution No. 29, see page 488, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 31

Procedure for Amendments to the Medical Practice Act of the State of Ohio

"Resolution No. 31, introduced by the Academy of Medicine of Cincinnati, was reviewed.

"The acting secretary of the State Medical Board had informed the chair that at the present time the recommendations of this resolution were already in the process of study and change. The Council of the Ohio State Medical Association is collaborating in this effort and for this reason, Mr. President, I move that Resolution No. 31 be **not** adopted."

By official action, the recommendation of the committee, namely, that Resolution No. 31 be NOT adopted, was approved.

(For text of Resolution No. 31 see page 488, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 33

Industrial Commission Usual and Customary Fee

(By Charles H. McMullen, M. D., Delegate, Ashland County)

WHEREAS, the Industrial Commission of Ohio and the Bureau of Workmen's Compensation have initiated a program of reimbursing physicians their usual and customary fees for professional medical care of Workmen's Compensation cases, and

WHEREAS, this program demonstrates a spirit of cooperation with and confidence in the physicians of Ohio, and

WHEREAS, this usual and customary fee program reflects sound leadership in the administration of the responsibilities of the commission and the bureau, THEREFORE BE IT

RESOLVED, that this House of Delegates of the Ohio State Medical Association officially commends the Industrial Commission of Ohio and the Bureau of Workmen's Compensation for this program, AND BE IT FURTHER

RESOLVED, that the component county medical societies and their members continue to extend their full cooperation and assistance in helping to insure the successful administration of this usual and customary fee program.

"Resolution No. 33 was introduced by Dr. Charles H. McMullen, delegate from Ashland County. This resolution was accepted for discussion. It commends the Industrial Commission of Ohio for its forward and ongoing program of adequate compensation.

"The committee recommends the adoption of Resolution No. 33, as submitted, and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 33 be adopted as submitted, was approved.

RESOLUTION NO. 38

Traffic Accidents and Medically Incompetent Aged Drivers

"Resolution No. 38 was submitted by the Lorain County Medical Society. There was considerable discussion from the assembled delegates pointing to the fact that this resolution is discriminatory and, further, to the fact that the determination of medical infirmities should not be the proper purview of the Highway Department; and that the inabilities to properly manage a motor vehicle insofar as physical infirmities are concerned have no dependency on chronologic age. Your committee, therefore, is in agreement that Resolution No. 38 be **not** adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 38 be NOT adopted, was approved.

(For text of Resolution No. 38 see page 490, May, 1966 issue of *OSMJ.*)

RESOLUTION NO. 44 AND RESOLUTION NO. 46

"Resolution No. 44 entitled 'Medical Ethics' was submitted by the Huron County Medical Society. Resolution No. 46 entitled 'Compliance with the Civil Rights Act of 1964' was introduced by the Councilor of the Second District on the floor of the House. These resolutions were considered together. While Resolution No. 44 is entitled 'Medical Ethics' the content and import of the resolution was such that the committee felt it should not be immediately remanded to The Council on the basis of its ethical content. However, Resolution No. 46 pointed out that action had already been initiated in the House of Delegates of the American Medical Association at the October, 1965, meeting. It was further pointed out that in spite of the action taken at the AMA meeting there were still many problems with billing in the State of Ohio for welfare cases. Since Resolution No. 46 supersedes Resolution No. 44, the committee recommends that Resolution No. 44 be **not** adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 44 be NOT adopted, was approved.

(For text of Resolution No. 44 see page 491, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 46

Compliance with Civil Rights Act of 1964

"Resolution No. 46, which was introduced on the floor of the House, read as follows:



The entire Annual Meeting was dedicated to Dr. Herbert M. Platter. Here, at the first session of the House of Delegates, President Crawford is presenting Dr. Platter with a copy of the dedicatory resolution inscribed in bronze. Hart F. Page, OSMA, Executive Secretary, is holding the color television set also presented to Dr. Platter.



Past Presidents of the Association are shown here at the dinner meeting of The Council. Front row, from left, Drs. H. T. Pease, George A. Woodhouse, Paul A. Davis, H. M. Platter, L. Howard Schriver; Carl A. Lincke, and Harve M. Clodfelter. Standing, from left, are Drs. Edwin H. Artman, Robert E. Tschantz, Frank H. Mayfield, George W. Petznick, Charles L. Hudson, Henry A. Crawford (Outgoing President), and George J. Hamwi.

All physicians, as citizens of the United States, are bound by the laws of the United States. There is no need to demean them by asking an oath of compliance to those laws and their regulations. Especially not for the receipt of remuneration for services rendered to welfare recipients.

The Ohio Department of Welfare has again notified physicians of Ohio that, "We regret very much that we are not in a position to pay the enclosed bills without the assurance of compliance with the Civil Rights Act of 1964 as required by federal law and regulations."

In October 1965 the House of the American Medical Association passed a resolution stating that the House of Delegates directs the Board of Trustees and the Officers of this Association to oppose actively and forcefully this and any future attempts by HEW or any other federal agency to impose conditions and pledges upon the medical profession. THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association petition the Board of Trustees and the Officers of the American Medical Association to actively and forcefully oppose the requirement of the federal law and regulations that ask assurance of compliance with the Civil Rights Act of 1964 from individual citizens, even through the Supreme Court.

"The committee recommends an editorial deletion of the last sentence of the first paragraph. Mr. President, the committee recommends the adoption of Resolution No. 46 with the deletion, and I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 46, with an editorial deletion of the last sentence of the first paragraph, be adopted, was approved.

The amended paragraph reads as follows:

All physicians, as citizens of the United States, are bound by the laws of the United States. There is no need to demean them by asking an oath of compliance to those laws and their regulations.

RESOLUTION NO. 47
Reimbursement of Costs for Collection of Dues

"Resolution No. 47, introduced by the delegates from Hamilton County, was inadvertently omitted from the printed resolutions. It read as follows:

WHEREAS, the Ohio State Medical Association and the American Medical Association have increased the demands on local County Medical Societies for additional services; and

WHEREAS, the increase in demands by the Ohio State Medical Association and the American Medical Association through extended programs require additional expenditures by County Medical Societies; THEREFORE BE IT

RESOLVED, that the County Medical Society be reimbursed for costs expended in the collection of dues and the certification of membership to both the Ohio State Medical Association and the American Medical Association.

"The committee reviewed the resolution. There was no one to speak to the resolution. However, it was pointed out by the executive office that for several years at the direction of The Council the rebate from the AMA had been turned over to the AMA-ERF fund. It was pointed out further that the difficulty to be encountered in the OSMA headquarters office seemed out of proportion to the financial benefits to be derived by the component societies.

"For the above reasons your committee agrees with what seems to be a proper distribution of this rebate and recommends that Resolution No. 47 be **not** adopted. Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 47 be NOT adopted, was approved.

"I would like to extend a debt of gratitude to all of those members of the society and visiting experts who gave of their time and knowledge to enable the committee to arrive at the decisions. I would personally like to extend my thanks to the members of the committee who made the summation and present report possible. The members of the committee are as follows: Carl A. Minning, Clermont County; Isador Miller, Champaign County; D. L. Becker, Allen County; Robert A. Irvin, Lake County; Charles W. Stertzbach, Mahoning County; Norman L. Wright, Coshocton County; Kenneth E. Bennett, Washington County; Jasper M. Hedges, Pickaway County; Charles H. McMullen, Ashland County; F. P. Osgood, Lucas County, *Chairman.*

By official action, the report of Resolutions Committee No. 1 as a whole, as amended, was approved.

Report of Resolutions Committee No. 2

Dr. John H. Budd, Cuyahoga County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"Resolutions Committee No. 2 considered seventeen resolutions having to do with a variety of issues and subjects. Discussion was frank, sincere and unabridged. Where differences of opinion became evident, they were debated temperately, astutely and concisely, with conspicuous concern for the welfare of our patients, and for preservation of highest quality medical care.

"Resolutions 7 through 14, 19 and 20, 22 and 43 will be dealt with in a group, after consideration of the resolutions which now follow:

RESOLUTION NO. 21
Military Dependents' Medical Care

"Resolution No. 21, introduced by the delegates of Stark County, recommends that the administrative regulations of the Military Dependents' Medical Care program be modified to provide the same options of reimbursement as are available under Part B, Public Law 89-97. The committee is in hearty accord with this provision and recommends adoption of the resolution with the addition of a Resolve that a similar resolution be presented to the AMA House of Delegates at the June meeting."

'BE IT FURTHER RESOLVED, that the OSMA Delegates to the AMA offer a resolution seeking accomplishment of this purpose.'

"Mr. President, I move the adoption of Resolution No. 21, as amended."

By official action, the recommendation of the committee, namely, that Resolution No. 21, as amended, be adopted, was approved.

AMENDED RESOLUTION NO. 21
Military Dependents' Medical Care
(By the Stark County Medical Society)

WHEREAS, Public Law 89-97 provides the option of direct

reimbursement of patients eligible for benefits under Part B of said law, and

WHEREAS, Public Law 569 (Military Dependents Medical Care Act) 84th Congress, does not provide such an option, and

WHEREAS, the lack of such option destroys the physician-patient relationship, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association strongly recommends that all necessary actions be taken in order to provide that patients eligible for benefits under Public Law 569 be afforded the same option of reimbursement as is provided for patients eligible for benefits under Public Law 89-97, Part B.

BE IT FURTHER RESOLVED, that the OSMA Delegates to the AMA offer a resolution seeking accomplishment of this purpose.

(For the text of original Resolution No 21. see pages 485 and 486, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 32
Voluntary Health Insurance

"This resolution, introduced by the delegates from Stark County, asks that OSMA encourage the voluntary health insurance industry of Ohio to continue offering the benefits of their customary policies to persons over 65. This recommendation has been adopted by the AMA at a national level.

With minor modification, the committee recommends that the resolution be adopted. The amended resolution reads as follows:

AMENDED RESOLUTION NO. 32
Voluntary Health Insurance

Preamble

A direct result of organized medicine's effort to forestall King-Anderson type legislation was the emergence of a splendid voluntary health insurance industry which extended coverage to persons over 65. We believe that there are many people over 65 who would prefer to continue their voluntary health insurance, if it is still available to them.

It is the declared intent of labor to extend the principles of P. L. 89-97 to persons of all ages. If this effort is successful over the American Medical Association's campaign to repeal portions of the present law, the voluntary health insurance industry and the public will suffer a grievous blow.

Blue Cross Plans in some areas of the country already are announcing that at midnight on June 30, 1966 some contracts for persons 65 or older will be canceled. THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association make every effort to encourage the voluntary health insurance industry in Ohio not to cancel contracts but to continue offering improved contracts to persons 65 and older, and that contracts should not be confined to supplementing P. L. 89-97 but should be written to meet the wide variety of needs for persons over 65.

"Mr. President, I move the adoption of Amended Resolution No. 32."

By official action, the recommendation of the committee, namely, that amended Resolution No. 32 be adopted, was approved.

(For text of Resolution No. 32 see pages 488-489, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 35
Aircraft Safety

"This resolution, introduced by the delegates of the Academy of Medicine of Cleveland, manifests the concern of the medical profession for safety in air transportation and interest in constructive, regulative legislation. After hearing of testimony on this resolution and after discussion, your committee recommends the following Substitute Resolution:

SUBSTITUTE RESOLUTION NO. 35
Aircraft Safety

WHEREAS, air travel is a major means of transportation today, and

WHEREAS, it is used by many persons, and

WHEREAS, the magnitude of an air crash tragedy is usually proportional to the number of passengers on board, and

WHEREAS, some pilot error and mechanical failure are inevitable, and

WHEREAS, speedy evacuation of still-living passengers after a crash is absolutely necessary if their lives are to be saved, THEREFORE BE IT

RESOLVED, that the Federal Aviation Agency give serious consideration to (1) increase in the minimum seating space per passenger, (2) improved means of emergency egress, and (3) judicious limitation of the number of passengers allowed on any one commercial aircraft.

"Mr. President, your Committee recommends the adoption of Substitute Resolution No. 35, and **I so move.**"

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 35 be adopted, was tabled.

(For text of Resolution No. 35, see page 489, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 36
Public Health

"This resolution, introduced by the delegate from Huron County, is concerned with menaces to public health from commercially imported contaminated articles. The committee endorses the intention of the resolution and offers a substitute resolution, to wit.

SUBSTITUTE RESOLUTION NO. 36
Public Health

WHEREAS, in 1962 and 1965, this country witnessed several examples of material, toys, "ice balls," and trinkets, grossly contaminated imported from other countries and being freely sold in this country, thereby creating a potential threat to the public health, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association instruct its delegates to the AMA to introduce and support a resolution instructing the appropriate committee of the AMA to work with the proper public health authorities to insure that the health of the American public is better protected from such dangers.

"Mr. President, I move the adoption of Substitute Resolution No. 36."

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 36 be adopted, was approved.

(For text of Resolution No. 36, see page 489, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 42
Defining "receipted bill" for Participants of Part B of Medicare

This resolution, introduced by the delegate from Huron County, voices a recommendation which in the opinion of the committee and those who testified, possesses much merit. It should be pointed out that

the accomplishment of the purpose requires a change in the present law. Also this policy has been approved by the AMA by adoption of a similar resolution from California in December 1965. Accordingly, your committee recommends that the language of the resolution be changed, and that its amended form read as follows:

AMENDED RESOLUTION NO. 42
Defining "receipted bill" for Participants of Part B of Medicare

WHEREAS, Public Law 89-97 requires a receipted doctor's bill from participants of Part B of Medicare, before money will be *disbursed* to said participants, and

WHEREAS, a bill cannot be receipted until paid, and

WHEREAS, this requirement will constitute an unreasonable hardship for patients, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association recommend that the Department of Health, Education, and Welfare establish the principle that a bill for services rendered by the physician be honored *in lieu of* a receipted bill and BE IT FURTHER

RESOLVED, that the Ohio State Medical Association through appropriate channels seek remedial legislative action to amend Public Law 89-97, Part B, Title 18 by deleting the words "receipted bill" and substituting "bill for services rendered" in Section 1842 (b) (3) (II).

"Mr. President, I move the adoption of the Resolution, as amended."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 42 be adopted, was approved.

(For text of Resolution No. 42, see page 491, May, 1966 issue *OSMJ.*)

Floor amendments to the resolution included the substitution of the word "disbursed" for the word "refunded" in the first WHEREAS and substitution of the words "in lieu of" for the word "as" in the first RESOLVED paragraph. The two floor amendments to the amended resolution are shown in Italics.

RESOLUTION NO. 45
Subscribers to Part B of Medicare Are Entitled To Treatment as Private Patients
(By Academy of Medicine of Cleveland)

WHEREAS, the "Modification of Proposed Third Principle Payment for Services Involving Residents and Interns," as embodied in Part B of the Medicare Law, states, as follows:

> "In the case of Major Surgical Procedures, as defined by the Joint Commission on Accreditation of Hospitals, and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician," and

WHEREAS, since this principle is designed to safeguard that high caliber of professional care which the profession is committed to provide, and

WHEREAS, The American College of Surgeons Committee on Medicare has proposed modification of this principle in such manner that the patients, for whom payment will be made under Title #18 of the Medicare Law, would, in many institutions, be placed under the "complete responsibility" of interns and residents in training, and that this further connotes lack of personal supervision by the attending physician, and

WHEREAS, such a modification would approve a procedure wherein a physician would receive compensation for services which he did not personally provide to the patient, and

WHEREAS, such receipt of compensation would be both unethical and dishonest, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association hereby records itself in support of the principle that subscribers to Part B of Medicare, by payment of premium, have purchased the same rights to personal medical care enjoyed by any other private patient, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association hereby records itself in support of the principle that professional responsibility of a physician, for services rendered by an intern or resident implies personal supervision and direction, in order to be considered identifiable and compensable service, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association instruct its Delegation to the American Medical Association to present this Resolution at the annual meeting of June 26-30, 1966, seeking its adoption, AND BE IT FURTHER

RESOLVED, that a copy of this Resolution be forwarded to the Secretary of The Department of Health, Education, and Welfare.

"This resolution, introduced from the floor, intends to establish certain principles with regard to beneficiaries and Part B of the Medicare Law and the reimbursement of physicians supervising professional services rendered patients by interns and residents in training. It is recommended that the resolution be amended by modifying the third WHEREAS, to read as follows:

"WHEREAS, modification of this principle has been proposed which would provide that the patients, for whom payment will be made under Title 18 of P. L. 89-97 would, in many institutions, be placed under the 'complete responsibility' of interns and residents in training, which modification further connotes lack of personal supervision by the attending physician."

"The committee also recommends the addition of the words 'and to the Health Insurance Benefits Advisory Council (H.I.B.A.C.)' to the last Resolve"

AMENDED RESOLUTION NO. 45
Subscribers to Part B of Medicare Are Entitled To Treatment as Private Patients
(By Academy of Medicine of Cleveland)

WHEREAS, the "Modification of Proposed Third Principle Payment for Services Involving Residents and Interns," as embodied in Part B of the Medicare Law, states, as follows:

> "In the case of Major Surgical Procedures, as defined by the Joint Commission on Accreditation of Hospitals, and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician," and

WHEREAS, since this principle is designed to safeguard that high caliber of professional care which the profession is committed to provide, and

WHEREAS, modification of this principle has been proposed which would provide that the patients, for whom payment will be made under Title 18 of P. L. 89-97 would, in many institutions, be placed under the "complete responsibility" of interns and residents in training, which modification further connotes lack of personal supervision by the attending physician.

WHEREAS, such a modification would approve a procedure wherein a physician would receive compensation for services which he did not personally provide to the patient, and

WHEREAS, such receipt of compensation would be both unethical and dishonest. THEREFORE BE IT



Three principals among the Association's officers for the coming year are shown at the President's Reception. From left, President-Elect Robert E. Howard, President Lawrence C. Meredith, and Immediate Past President Henry A. Crawford.



Shown holding the certificates of humanitarian service presented at the House of Delegates session for their work tours in Vietnam are, from left, Dr. John E. Stephens, Columbus; Dr. C. W. Hullinger, Springfield; Dr. William Barratt, Painesville; Dr. Buel S. Smith, Akron; and Dr. Alexander Miller, Cleveland Heights. (Others authorized to receive the certificates, but not present at the meeting, are Dr. Frank Gatti, Portsmouth; Dr. Aaron Isaac Grollman, Cincinnati; Dr. Charles U. Hauser, Hamilton; Dr. Hobart E. Klaaren, Dayton; and Dr. Paul R. Miller, Columbus.)

RESOLVED, that the Ohio State Medical Association hereby records itself in support of the principle that subscribers to Part B of Medicare, by payment of premium, have purchased the same rights to personal medical care enjoyed by any other private patient, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association hereby records itself in support of the principle that professional intern or resident implies personal supervision and direction, in order to be considered identifiable and compensable service, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association instruct its Delegation to the American Medical Association to present this Resolution at the annual meeting of June 26-30, 1966, seeking its adoption, AND BE IT FURTHER

RESOLVED, that a copy of this Resolution be forwarded to the Secretary of The Department of Health, Education, and Welfare, and to the Health Insurance Benefits Advisory Council (H. I. B. A. C.).

By official action, the recommendation of the committee, namely, that Amended Resolution No. 45 be adopted, was approved.

RESOLUTIONS 7, 8, 9, 10, 11, 12, 13, 14, 19, 20, 22 and 43
Series of Principles on Government Medical Care Programs

"As mentioned in the beginning, a large number of the resolutions were concerned with government-financed health care programs in general and P. L. 89-97 in particular and their impact on the legal, ethical, traditional and fiscal aspects of the physician-patient relationship. Because of the similar subject matter and the inter-relationships of these resolutions, your reference committee, instead of dealing with each separately, has considered their language and intent, and offers for adoption a series of principles, parts of which are extracted from the OSMA Council Policy Statement on Government Medical Care Programs. We believe that they express the policies of this Association on the issues under consideration."

1. Definitions

   Usual — The "usual" fee is that fee usually charged for a specific service provided by an individual physician for his patient.

   Customary — A fee is "customary" when it properly reflects the extent and nature of the services provided the patient.

   Reasonable — A fee is "reasonable" when it meets the "usual and customary" criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration. In cases where review or mediation may be requested, it is recommended that the standard mediation or review mechanism of the county medical society be utilized. Further, it is recommended that no special review or mediation committee be appointed solely to handle cases involving Public Law 89-97.

2. Ohio's Usual and Customary Fee Contrasted with Prevailing Fee

   (a) Ohio's individual physician's usual and customary fee program is an indemnity type insurance; national prevailing fee is a service contract.

   (b) Ohio's individual physician's usual and customary fee (Ohio Medical Indemnity) program pays all physicians their usual and customary charges to persons with incomes of $7,500 or less in counties where it is offered. In national prevailing fee programs, the physicians first must submit a detailed report on all their usual charges and only those physicians are included whose charges fall within the 90th percentile of charges submitted.

   (c) Under Ohio's individual physician's usual and customary program, physicians do not have to sign contracts to participate. Under the national prevailing usual and customary program only those physicians whose charges fall within the 90th percentile of the areawide charge are offered a contract to sign and these physicians must then sign a service contract and agree to accept the payment from the carrier as payment in full.

3. Physician-Patient Relationship

   Once the physician accepts a person as his patient, regardless of what third party might be involved, the physician's primary and sole obligation, his contract and his relationship are with the patient.

   Any arrangement between government and a citizen whereby the government agrees to pay for the citizen's medical care does not, directly or indirectly, or by inference, involve the physician in a contract with the government.

4. Billing and Reimbursement

   It is the official policy of this Association that every physician bill and receive for his professional medical services his usual, customary, and reasonable fee. This policy applies to governmental agencies at all levels.

   The physician is requested and urged to deal directly and only with the patient, both in providing medical care and in billing for just and reasonable compensation for the medical care provided.

5. Direct Billing vs Assignment

   It is recommended, inasmuch as the agreement for financial responsibility is between the patient and the government, that the physician not accept assignment forms.

   It is further recommended that each and every member of this Association submit to the patient his own bill and receive on his own behalf, compensation for his professional medical services.

6. Maintenance of Quality Medical Care

   This association and the AMA are on record as opposing any system of medicine which would lead to a deterioration of the quality of medical care.

   In assessing conditions which might lead to deterioration of this quality, Ohio physicians are advised to give heed to Section 6 of the Principles of Medical Ethics which provides "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care," and to the Nine Principles for Standards of Health Care Programs submitted by the Ohio delegation to the AMA House of Delegates (Feb. 6-7, 1965), adopted by that House of Delegates and since reiterated (Oct. 2-3, 1965).

"Mr. President, your committee recommends the adoption of this series of principles and I so move."

By official action, the recommendation of the committee, namely, that this resolution encompassing a series of principles regarding government medical care programs be adopted, was approved.

(For text of Resolutions 7, 8, 9, 10, 11, 12, 13, 14, 19, 20, 22 and 43, see pages 482, 483, 484, 485, 486, 491, May, 1966 issue *OSMJ.*)

SUBSTITUTE RESOLUTION
Date of Implementation of Usual and Customary Fee Policy for Welfare Programs in Ohio.

"Acknowledging the valid concern expressed in several resolutions that the policy of usual and customary fees receive prompt and adequate dissemina-

tion to the Association membership and the welfare agencies involved, your committee has drafted a Substitute Resolution to accomplish this purpose. The Substitute Resolution reads as follows:

WHEREAS, governmental agencies of Ohio at all levels have assumed financial responsibility for medical care of welfare recipients; THEREFORE, BE IT

RESOLVED, that OSMA notify such agencies that members of OSMA will expect usual and customary fees for professional services to welfare clientele beginning July 1, 1966, the date that Part B of P. L. 89-97 becomes effective.

"Mr. President, I move the adoption of this Substitute Resolution."

By official action, the recommendation of the committee, namely, that the Substitute Resolution on Usual and Customary Fee Policy for Welfare Programs in Ohio be adopted, was approved.

"Mr. President, I move the adoption of the committee report as a whole."

"It has been a privilege for the members of the committee to act in your behalf. Your chairman has been the beneficiary of much wisdom, patience and indulgence from the committee members. It has been a stimulating memorable experience. The names of the committee members are as follows: Robert M. Woolford, Hamilton County; Robert A. Bruce, Montgomery County; Donald R. Brumley, Hancock County; V. William Wagner, Ottawa County; Maurice F. Lieber, Stark County; Robert E. Rinderknecht, Tuscarawas County; James A. L. Toland, Guernsey County; William M. Singleton, Scioto County; Homer A. Anderson, Franklin County; Albert Burney Huff, Wayne County; John H. Budd, Cuyahoga County, *Chairman.*

By official action, the report of the Resolutions Committee No. 2 as a whole, as amended, was adopted by the House of Delegates.

Report of Resolutions Committee No. 3

Dr. James C. McLarnan, Knox City, reported for Resolutions Committee No. 3, of which he was chairman. The report read as follows:

"Resolutions Committee No. 3 considered 12 resolutions. Discussion was thorough, enlightening and unrestricted. All who wished to testify were heard. Testimony was given full and thoughtful consideration by the committee.

RESOLUTION NO. 27

AAPS Essay Contest

(By the Columbus Academy of Medicine)

BE IT RESOLVED, that the House of Delegates of the Ohio State Medical Association endorse the Essay Contest of the Association of American Physicians and Surgeons with the titles: (1) The Advantages of the American System of Private Medical Care and (2) The Advantages of the American Free Enterprise System.

"The first resolution considered by the committee was introduced by a delegate from Franklin County. This has been a traditional resolution before the Association. No objections were heard and this committee unanimously recommends its adoption. Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 27 be adopted, was approved.

RESOLUTION NO. 25

Commendation to OSMA Officers, Ohio's AMA Delegation and Staff of the OSMA

This resolution was introduced by the Huron County Medical Society. The committee was in full accord with the intent of the resolution but amended it to read as follows:

AMENDED RESOLUTION NO. 25

Commendation to OSMA Officers, Ohio's AMA Delegation and Staff of the OSMA

WHEREAS, the officers and all members of the Ohio delegation to the Clinical Conference of the American Medical Association, November, 1965, showed superb resolve in action, and put forth untiring efforts in the interest of the preservation of the private practice of medicine, and

WHEREAS, they were most loyally complemented and helped in their efforts by the staff of the Ohio State Medical Association, and

WHEREAS, as a result of this effort, they were able to significantly influence the decisions of the American Medical Association House of Delegates, NOW THEREFORE, BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association, on behalf of the physicians of Ohio, convey to said officers and members of the Ohio AMA delegation and the staff of the Ohio State Medical Association their thanks and appreciation.

"The committee recommends the adoption of Amended Resolution No. 25 and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 25 be adopted, was approved.

(For text of Resolution No. 25 see page 486, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 28

In Opposition to the Fluoridation of Public Drinking Water Supplies

"This resolution, introduced by Dr. Joseph G. Crotty, Hamilton County, was the subject of a lengthy and spirited debate. I believe that all arguments pro and con were heard and the committee commends the participants in the discussion for their rational arguments and lack of sensationalism.

"The committee could find no valid arguments advanced to cause a change in OSMA policy concerning fluoridation, adopted in 1957, which reads as follows:

'1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1 ppm of fluorine in drinking water has been established as a method of reducing dental caries in children up to 10 years of age. In localities with warm

climates, or where for other reasons the ingestion of water or other sources of considerable fluoride content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least 44 years of age.

'2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1 ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries-inhibiting effect of the fluoride.

'3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of 1 ppm of fluorine.

'The Council of the Ohio State Medical Association is of the opinion that projects involving fluoridation of public water supplies should have the prior approval of the county medical society and the local dental society serving the area, as well as the appropriate agencies of local government.'

"The Committee recommends, therefore, that this resolution **not** be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 28 NOT be adopted, was approved.

(For text of Resolution No. 28 see page 487, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 37
Health Insurance for Migrant Workers

"Resolution No. 37 was introduced by the Huron County Medical Society. The discussion brought forth the need for some type of health insurance coverage for migrant workers and the committee proposed an Amended Resolution No. 37, as follows:

AMENDED RESOLUTION NO. 37
Health Insurance for Migrant Workers

WHEREAS, seasonal migrant workers are imported into the State of Ohio,

WHEREAS, these workers and their families often need medical and hospital care, and

WHEREAS, a majority of these workers do not carry health insurance, and

WHEREAS, many communities are left with sizable unpaid hospital and medical bills as the migrant workers leave the communities in which they were temporarily employed, THEREFORE, BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct the officers and staff of the Association to meet with insurance carriers and an appropriate agency for the State of Ohio, to attempt to resolve the problem of adequate health insurance for these migrant workers."

"The committee recommends the adoption of this amended resolution and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 37 be adopted, was approved.

(For text of Resolution No. 37 see pages 489-490, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 40
Condemning Actions Taken by Many Blue Cross Plans

"This resolution was presented by the Huron County Medical Society. The committee felt this to be somewhat confusing and testimony did not reveal a clear cause for a new action.

"Therefore, this committee recommends this resolution **not** be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 40 NOT be adopted, was approved.

(For text of Resolution No. 40 see page 490, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 15
Hospital Admission

"This resolution was submitted by the Mahoning County Medical Society. Testimony was convincing and to the point. The committee feels that, although this is present American Medical Association policy, the principle is of sufficient importance to justify reaffirmation by the Ohio State Medical Association. It was felt that the resolution could be clarified by omitting the fourth 'Whereas' and by amending the 'Resolved' portion with the amended resolution reading as follows:

AMENDED RESOLUTION NO. 15
Hospital Admission

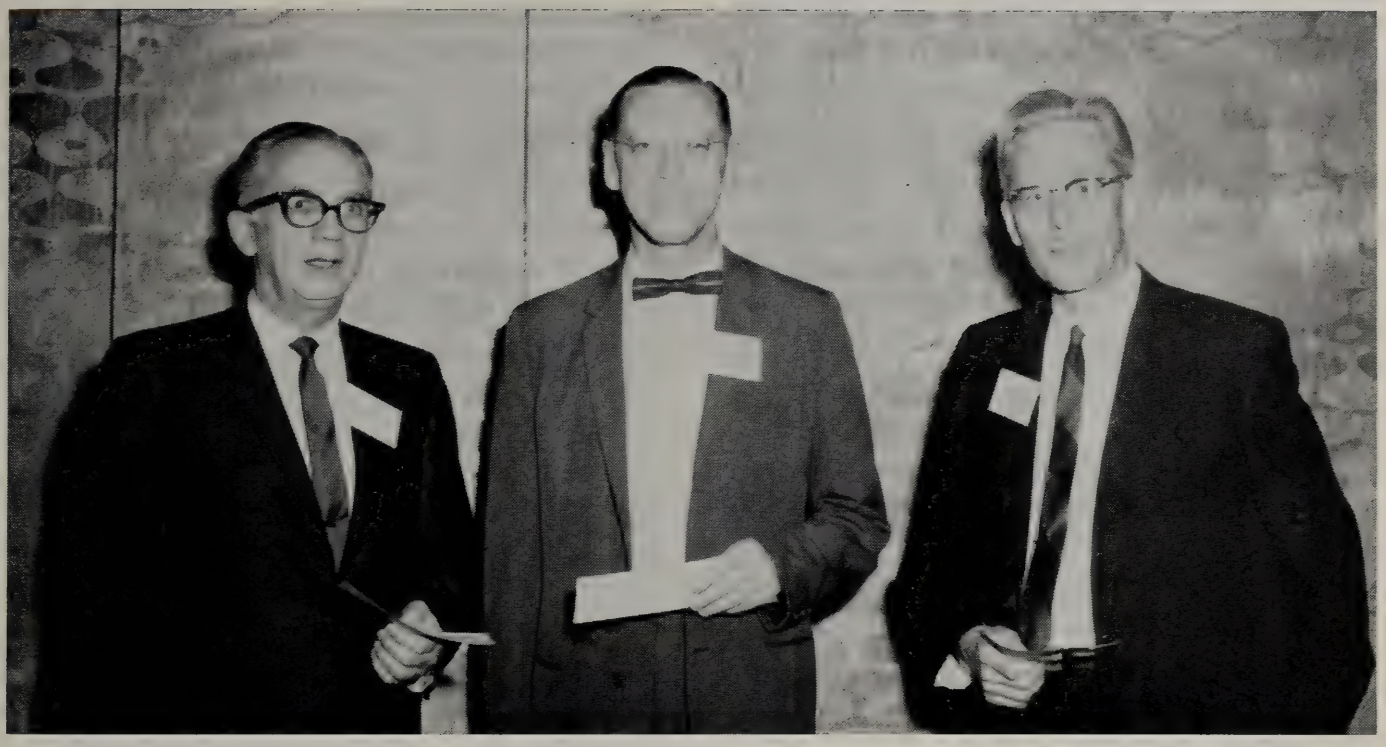
WHEREAS, Public Law 89-97 (Medicare) may require federal forms for physician certification of hospital admission, and

WHEREAS, the American Medical Association during its October 2-3, 1965 meeting, adopted the policy that "current practices and customary procedures with respect to certification for hospital admission and care shall be continued under Public Law 89-97" and

WHEREAS, the current admissions practice in most Ohio hospitals is an oral request for bed facilities, followed by the signing of the patient's hospital chart after the patient's admission, THEREFORE, BE IT

RESOLVED, that the Ohio State Medical Association affirms the principle that the certification of patients for hospital admission and care be the same for all patients: i.e., a physician may ethically continue to use the current practice for hospital admissions without discrimination as to age.

"The committee recommends the adoption of Amended Resolution No. 15, and Mr. President, I so move."



Checks representing Ohio Schools' proportion of AMA-ERF funds were presented to representatives of the schools. From left are Dr. John A. Prior, associate dean, Ohio State University College of Medicine; Dr. Robert M. Woolford, representing the University of Cincinnati College of Medicine; and Dr. Robert F. Parker, assistant dean, Western Reserve University School of Medicine.



A number of panels contributed to the extensive scientific program. Here is the panel on "Marriage Problems." At the rostrum is Miss Myra F. Thomas, of the Family Service Association. At the table, from left, are Dr. Leonard L. Lovshin, Dr. George T. Harding, Dr. Frances K. Harding, and the Very Reverend David Loegler, Dean of Trinity Cathedral in Cleveland.

By official action, the recommendation of the committee, namely, that Amended Resolution No. 15 be adopted, was approved.

(For text of Resolution No. 15 see page 484, May, 1966 issue of *OSMJ.*)

RESOLUTION NO. 34

Industrial Commission-Physician Ethical Relationship Concerning Prescriptions

"Resolution No. 34 was introduced by the Lorain County Medical Society but provoked little discussion at the committee hearing. It is the opinion of your committee that no real problem lies in this area at the present time. The committee recommends that this resolution be **not** adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 34 be NOT adopted, was approved.

(For text of Resolution No. 34 see page 489, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 23

Endorsement of the "Open Staff"

"Resolution No. 23 was submitted by the delegates of the Summit County Medical Society. There was much discussion concerning the reason for submission of this resolution. The committee felt that there was adequate justification for a statement concerning this problem and submits the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 23

Endorsement of the "Open Staff"

WHEREAS, the policy of "open staff" in hospitals is believed to provide and encourage the best quality of medical care, and

WHEREAS, there is no conflict between medical education programs and "open staff" hospitals, THEREFORE, BE IT

RESOLVED, that the Ohio State Medical Association, representative of most physicians, exert its influence so as to assist all hospital staffs in providing excellent training programs and, at the same time, continuing its efforts to maintain the principle of "open staff" hospitals, and BE IT FURTHER

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct their delegates to the American Medical Association to present a similar resolution to a future meeting of the House of Delegates.

"The committee recommends that Substitute Resolution No. 23 be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 23 be adopted, was approved.

(For text of Resolution No. 23 see page 486, May, 1966 issue *OSMJ.*)

RESOLUTIONS NO. 16 AND 18

Reimbursement for Services of Hospital-Based Physicians

"These resolutions concerning reimbursement for services of hospital-based physicians were considered jointly. The discussion was lively and showed progress in the continuing struggle to give hospital-based physicians their proper recognition as practicing physicians. It was felt by the committee that both resolutions had merit and could be better expressed in a combined resolution which the committee submits as Substitute Resolution No. 16.

SUBSTITUTE RESOLUTION NO. 16

Reimbursement for Services of Hospital-Based Physicians

WHEREAS, the MEDICARE LAW (P. L. 89-97) establishes separate provisions for hospital care and for coverage of physicians' services, and

WHEREAS, Section 1701.03 of the Revised Code of Ohio prohibits the practice of a profession by a lay corporation and Opinion 1751 of the Attorney General of Ohio states specifically that a corporation, whether or not organized for profit, cannot lawfully engage in the practice of medicine in Ohio, and

WHEREAS, the national governing bodies of the concerned physician specialists and the American Medical Association have issued policy statements recommending fee for service arrangements and direct billing of individual patients, NOW, THEREFORE, BE IT

RESOLVED, that the Ohio State Medical Association endorse and actively support the position of *all* physicians in altering whatever hospital contracts as are necessary, to establish a normal and ethical relationship, and BE IT FURTHER

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct The Council of the Ohio State Medical Association to petition the Director of Insurance of the State of Ohio to require removal from all prepaid hospital insurance plans provisions for benefits covering physicians' services.

"The committee unanimously recommends that Substitute Resolution No. 16 be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 16, which combines Resolution No. 16 and Resolution No. 18, was approved. The word "all" was substituted for the words "hospital-based" in the second line of the first Resolved paragraph of the substitute resolution by floor amendment.

(For text of Resolution No. 16 and Resolution No. 18 see pages 484 and 485, May, 1966 issue of *OSMJ.*)

RESOLUTION NO. 17

Physicians, Ethics and the Corporate Practice of Medicine

"This resolution was introduced by the Stark County Medical Society. After hearing testimony concerning this resolution, the committee feels that this resolution should be augmented by the addition of another 'Whereas' and, on advice of the legal counsel of the Ohio State Medical Association, the 'Resolved' be amended, and we now submit Amended Resolution No. 17.

AMENDED RESOLUTION NO. 17

Physicians, Ethics and the Corporate Practice of Medicine

WHEREAS, the Ohio State Medical Association legal counsel has provided an excellent presentation of the ethical and legal aspects of the corporate practice of medicine, this presentation having been sent to all mem-

bers of this Association February 8, 1966, under the heading of "Special Medicare Newsletter No. 2," and

WHEREAS, Section 4, Principles of Medical Ethics, states, "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession," and

WHEREAS, Section 6 of the Principles of Medical Ethics reads as follows:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care," and

WHEREAS, the Judicial Council of the American Medical Association states (1966 Opinions and Reports, Page 16, Section 4, Article 9):

"OBLIGATIONS OF COUNTY MEDICAL SOCIETIES

"The Council has emphasized the autonomy of the county society and the fact that such autonomy imposes responsibilities. If medical societies fail to accept and discharge their obligations in matters of ethics, others will assume these obligations by default. The Judicial Council urges county and state societies to adopt critical attitudes toward their programs to 'uphold the honor and dignity' of the profession of medicine. These programs must be based on a sound knowledge and understanding of ethical principles. As long as ethical principles are widely and sedulously observed, the reputation of the medical profession will be upheld. The reward will be commensurate with the services rendered in the observation of these ideals. On the other hand, if there is flagrant or even careless disregard of ethical principles, the reputation of the profession of medicine will suffer and its responsibilities and obligations will be usurped by others, (AMA House of Delegates, 1958)." NOW, THEREFORE, BE IT

RESOLVED, that this House of Delegates urges each Component Medical Society of this Association to be constantly on the alert for violations of the Principles of Medical Ethics, and for the appropriate committee of the Component Medical Society to investigate all situations, including contracts, where *there are reasonable grounds for believing that unethical practices exist.*

"The committee unanimously recommends that Amended Resolution No. 17 be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 17 be adopted, was approved with the substitution of the words "there are reasonable grounds for believing that unethical practices exist" for the words "suspicion of unethical practice exists" at the end of the final resolve paragraph. This further modification was suggested by the committee and accepted by the House.

(For text of Resolution No. 17 see pages 486 and 487, May, 1966 issue *OSMJ.*)

RESOLUTION NO. 30

Licensing Foreign Graduates

"The last resolution discussed by Resolutions Committee No. 3 was Resolution No. 30, submitted by the delegates of the Summit County Medical Society. The testimony heard by the committee brought out the fact that this was a small part of a major problem concerning the rules of the State Medical Board and foreign medical graduates. Although the committee understands that this is a problem in some areas, it is felt that a resolution at this time is not appropriate. The committee recommends that this resolution be referred to The Council to be assigned to an appropriate committee of the Ohio State Medical Association for further study, and an appropriate resolution be introduced at a future meeting of the House of Delegates if deemed advisable. Mr. President, I so move."



Dr. David Fishman, President of the Academy of Medicine of Cleveland, officially opened the House of Delegates and welcomed members and guests of the Association to Cleveland.



Principal speaker for the OMPAC-AMPAC luncheon meeting was Dr. Hoyt D. Gardner, member of the AMPAC Board of Directors, who is shown here discussing the topic, "Success Can Be Ours."

By official action, the recommendation of the committee, namely, that Resolution No. 30 be

referred to The Council of the Ohio State Medical Association to be assigned to an appropriate committee for further study, was approved.

(For text of Resolution No. 30 see page 488, May, 1966 issue *OSMJ.*)

"Mr. President, I move the adoption of the Report of Resolutions Committee No. 3 as a whole, as amended."

The House of Delegates approved the motion by official action.

"The committee is appreciative of the testimony that was received by it and the courtesy shown the committee by all who appeared. As Chairman, I wish to express my appreciation to the members of the committee for their consideration, wisdom and vision and to acknowledge the excellent secretarial staff of the Association."

The members of the committee are: Thomas E. Fox, Warren County; Maurice M. Kane, Darke County; Walter A. Daniel, Seneca County; William J. Neal, Fulton County; William F. Boukalik, Cuyahoga County; James W. Parks, Summit County; James F. Sutherland, Belmont County; Carl E. Spragg, Muskingum County; Roger P. Daniels, Meigs County; Ben V. Myers, Lorain County; James C. McLarnan, Knox County, *Chairman.*

Resolutions Committees Thanked

On motion by Dr. Charles W. Pavey, Franklin County, and seconded by many, it was voted that this House of Delegates record its appreciation to all members of the Resolutions Committees for their outstanding performance in organizing and condensing an unwieldy amount of material into an understandable and useful set of resolutions.

Election of President-Elect

Dr. Crawford called for nominations for the office of President-Elect. Dr. Robert E. Rinderknecht, Tuscarawas County, placed in nomination the name of Dr. Benjamin C. Diefenbach, Martins Ferry, Councilor of the Seventh District. The nomination was seconded by Dr. Robert C. Beardsley, Zanesville, Eighth District Councilor.

Dr. Edmond K. Yantes, Clinton County, placed in nomination the name of Dr. Robert E. Howard, Cincinnati, First District Councilor. The nomination was seconded by Dr. Paul N. Ivins, Butler County. There being no further nominations, the balloting was conducted and **Dr. Howard was declared elected President-Elect.** Dr. Howard was escorted to the rostrum and he addressed the House of Delegates.

Election of Councilors

Dr. Edwin C. Winzeler, Henry County, as chairman, presented the report of the Nominating Committee. The report was as follows:

First District

As Councilor of the First District to succeed Dr. Robert E. Howard, Cincinnati, who was elected President-Elect, the committee placed in nomination the name of Dr. Frank P. Cleveland, Cincinnati. Dr. Cleveland asked that his name be withdrawn. Dr. Paul N. Ivins, Butler County was nominated from the floor. There being no further nominations, by official action the nominations were closed and **Dr. Ivins was declared elected Councilor of the First District for a term of two years, 1966-1967 and 1967-1968.**

Third District

As Councilor of the Third District to succeed himself, the committee placed in nomination the name of Dr. Frederick T. Merchant, Marion. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Merchant was declared re-elected Councilor of the Third District for a term of two years, 1966-1967 and 1967-1968.**

Fifth District

As Councilor of the Fifth District to succeed himself, the committee placed in nomination the name of Dr. P. John Robechek, Cleveland. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Robechek was declared re-elected Councilor of the Fifth District for a term of two years, 1966-1967 and 1967-1968.**

Seventh District

As Councilor of the Seventh District to succeed Dr. Benjamin C. Diefenbach, Martins Ferry, who had served the maximum number of terms under the Constitution and Bylaws, the committee placed in nomination the name of Dr. Sanford Press, Steubenville. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Press was declared elected Councilor of the Seventh District for a term of two years, 1966-1967 and 1967-1968.**

Ninth District

As Councilor of the Ninth District to succeed himself, the committee placed in nomination the name of Dr. George N. Spears, Ironton. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Spears was declared re-elected Councilor of the Ninth District for a term of two years, 1966-1967 and 1967-1968.**

Eleventh District

As Councilor of the Eleventh District to succeed himself, the committee placed in nomination the name of Dr. William R. Schultz, Wooster. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Schultz was**





The Association was honored to have among its distinguished speakers the Incoming President and a Past President of the American Medical Association. Ohio's Dr. Charles L. Hudson, (left) Incoming President of the AMA, discussed the effect of Medicare on the practie of medicine. Dr. Edward R. Annis, Miami, Florida, Past-President of the AMA and outstanding spokesman in behalf of maintaining the physician-patient relationship in medicine, spoke on "Care of the Patient — 1966."

declared re-elected Councilor of the Eleventh District for a term of two years, 1966-1967 and 1967-1968.

AMA Delegates and Alternates

The Nominating Committee then placed in nomination the following for the office of delegate and alternate to the American Medical Association for a term of two years beginning January 1, 1966:

Dr. Theodore L. Light, Dayton, delegate, and Dr. Kenneth D. Arn, Dayton, alternate.

Dr. Carl A. Lincke, Carrollton, delegate, and Dr. Robert S. Martin, Zanesville, alternate.

Dr. George W. Petznick, Cleveland, delegate, and Dr. Horatio T. Pease, Wadsworth, alternate.

Dr. Edmond K. Yantes, Wilmington, delegate, and Dr. Harry K. Hines, Cincinnati, alternate.

Due to increased AMA membership during 1965, the committee then proposed two candidates for the tenth delegate, namely, Dr. Robert E. Tschantz, Canton, and Dr. P. John Robechek, Cleveland. These candidates were proposed for election to a term of office for two years beginning January 1, 1967 and ending December 31, 1968, as well as a term ending December 31, 1966. The nominations being duly seconded and there being no additional nominations, official balloting was conducted and **Dr. Tschantz was declared elected delegate to the AMA for a term of two years beginning January 1, 1967 and a term ending December 31, 1966.**

As tenth alternate delegate for the two-year term and a term ending December 31, 1966, the committee placed in nomination Dr. Henry A. Crawford, Cleveland. The nomination being seconded and there being no additional nominations, **Dr. Crawford was declared elected alternate-delegate to the AMA for a two-year term beginning January 1, 1967 and a term ending December 31, 1966.**

The committee on Nominations presented two names for a candidate to succeed Dr. Robert Tschantz, whose term as alternate delegate expires December 31, 1967, namely, Dr. Frank F. A. Rawling, Toledo, and Dr. Robert C. Beardsley, Zanesville. The nominations being duly seconded and there being no further nominations, official balloting was conducted and **Dr. Frank F. A. Rawling, Toledo, was declared elected alternate-delegate to the AMA for a term expiring December 31, 1967.**

Inaugural Ceremoney

Dr. Crawford asked all the newly elected officers, councilors, delegates and alternates to come to the front of the room where they were officially installed into office.

Dr. Crawford then presented the official gavel of the Association to Dr. Meredith, the incoming President, and wished him every success for his year in office.

Dr. Tschantz, as immediate Past President, invited Mrs. Crawford to the rostrum and presented Dr. and Mrs. Crawford with a silver engraved tray as the Association's token of appreciation for his year of service as President of the Ohio State Medical Association. Also, a special certificate of honor was presented to Dr. Crawford for his service to the Association.

After he took office, Dr. Meredith presented Dr. Crawford with the official Past President's button.

Dr. Meredith then addressed the House of Delegates.

(See pages 723-724 for text of the inaugural address.)

Committees Named

Dr. Meredith made the following committee appointments which **were officially approved by the House of Delegates:**

Committee on Education — Dr. Thomas E. Rardin, Columbus, reappointed chairman for the ensuing year and reappointed for a five year term, 1966-1971.

Judicial and Professional Relations Committee — Dr. Frank F. A. Rawling, Toledo, reappointed chairman; Dr. Henry A. Crawford, Cleveland, appointed for a five-year term, 1966-1971.

Committee on Public Relations and Economics — Dr. Frederick P. Osgood, Toledo, reappointed chairman; Dr. Horace B. Davidson, Columbus, reappointed for a five-year term, 1966-1971.

Committee on Scientific Work — Dr. Samuel Saslaw, Toledo, reappointed chairman; Dr. Jerry Hammon, West Milton, appointed for a five-year term, 1966-1971. Dr. Robert E. Zipf, Dayton, appointed for a five-year term, 1966-1971.

Dr. Saslaw and OSMA Staff Commended

Dr. Samuel Saslaw, chairman of the Committee on Scientific Work, and all members of the OSMA staff were commended by the House of Delegates for the success of the meeting.

Decree Approved

Under new business Dr. Theodore L. Light, Second District Councilor, presented the following statement:

"In all functions of the House of Delegates of the Ohio State Medical Association Annual Meeting, May 24-28, discussion was frank, sincere and unabridged. Where differences of opinion became evident, they were debated temperately, astutely and concisely, with conspicuous concern for the welfare of our patients, and for the preservation of highest quality medical care."

By official action of the House of Delegates **the decree was adopted as presented.**

Emergency Resolution

A request from Dr. Jack Kraker, Fairfield County, to introduce an emergency resolution failed to receive the required two-thirds vote of those present, ruled necessary by the President for suspension of the rules.

Vote of Thanks

The House of Delegates expressed appreciation to the committees and staff of the Academy of Medicine of Cleveland and Cuyahoga County, to the Auxiliary, members of the news media, managements of the Cleveland hotels, and to all others who contributed to the success of the 1966 Annual Meeting.

Dr. Meredith announced that the 1967 Annual Meeting will be held in Columbus the week of May 14.

The House of Delegates then adjourned sine die.

Attest: HART F. PAGE
Executive Secretary

ROLL CALL OF HOUSE OF DELEGATES
1966 ANNUAL MEETING

County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	Francis Stevens	Present	Present
BROWN	John R. Donohoo	Present	Present
BUTLER	Paul N. Ivins	Present	Present
	John H. Varney	Present	Present
CLERMONT	Carl A. Minning	Present	Present
CLINTON	Edmond K. Yantes	Present	Present
HAMILTON	William C. Ahlering	Present	Present
	Frederick Brockmeier	Present	.....
	Frank P. Cleveland	Present	Present
	John J. Cranley, Jr.	Present	Present
	Joseph G. Crotty	Present	Present
	Ralph S. Grace	Present	Present
	Robert S. Heidt	.....	Present
	Harry K. Hines	Present	Present
	Daniel V. Jones	Present	Present
	Warner A. Peck	Present	.....
	Glenn W. Pfister, Jr.	Present	.....
	Clyde S. Roof	.....	Present
	R. M. Woolford	Present	Present
HIGHLAND	Clifford G. Foor	Present	Present
WARREN	Thomas E. Fox	Present	Present
	SECOND DISTRICT		
CHAMPAIGN	Isador Miller	Present	Present
CLARK	David D. Smith	Present	Present
	Ernest H. Winterhoff	Present	Present
DARKE	Maurice M. Kane	Present	Present
GREENE	Roger C. Henderson	Present	Present
MIAMI	Dale A. Hudson	Present	Present
MONTGOMERY	Kenneth D. Arn	Present	Present
	Robert A. Bruce	Present	.....
	C. E. O'Brien	.....	Present
	William M. Porter	Present	Present
	J. Richard Strawsburg	Present	Present
	James G. Tye	Present	Present
	Sylvan L. Weinberg	Present	Present
PREBLE	C. J. Brian	.....	.....
SHELBY	George J. Schroer	Present	Present
	THIRD DISTRICT		
ALLEN	Dwight L. Becker	Present	Present
	Fred P. Berlin	Present	Present
AUGLAIZE	Robert S. Oyer	.....	Present
	Elizabeth Y. Kuffner	Present	.....
CRAWFORD	Darrel D. Bibler	.....	.....
HANCOCK	Donald R. Brumley	Present	Present
HARDIN	Clarence L. Johnson	Present	Present
LOGAN	Charles A. Browning	Present	Present
MARION	Albert M. Mogg	Present	Present
MERCER	Donald R. Fox	Present	.....
SENECA	Walter A. Daniel	Present	Present

County	Delegate	First Session	Second Session
VAN WERT	Edwin W. Burnes	Present	----------
WYANDOT	Donald P. Smith	----------	----------
	FOURTH DISTRICT		
DEFIANCE	Charles E. Jaeckle	Present	Present
FULTON	Vernon L. Cotterman	----------	Present
	William J. Neal	Present	----------
HENRY	Edwin C. Winzeler	Present	Present
LUCAS	George Bates	Present	Present
	William G. Henry	Present	Present
	Frederick P. Osgood	Present	Present
	Frank F. A. Rawling	Present	Present
	Merl B. Smith	Present	Present
	Randolph P. Whitehead	Present	Present
OTTAWA	V. William Wagner	Present	Present
PAULDING	D. E. Farling	Present	----------
PUTNAM	Milo B. Rice	Present	Present
SANDUSKY	John G. Bushman	----------	----------
WILLIAMS	Allen G. Jackson	----------	Present
WOOD	Clarence Nyce	Present	Present
	FIFTH DISTRICT		
ASHTABULA	Shepard A. Burroughs	Present	Present
CUYAHOGA	Joseph C. Avellone	Present	Present
	James O. Barr	Present	Present
	Joseph L. Bilton	Present	Present
	William F. Boukalik	Present	Present
	John H. Budd	Present	Present
	E. Peter Coppedge, Jr.	Present	Present
	Eduard Eichner	Present	Present
	David Fishman	Present	Present
	William E. Forsythe	Present	Present
	John J. Grady	Present	Present
	Harry A. Haller	Present	Present
	Chester R. Jablonoski	Present	----------
	Fred R. Kelly	Present	Present
	Vincent T. LaMaida	Present	----------
	M. H. Lambright	Present	----------
	Richard P. Levy	----------	Present
	Frederick V. Light	----------	Present
	Lawrence J. McCormack	Present	Present
	Paul A. Mielcarek	Present	Present
	George W. Petznick	Present	Present
	Russell P. Rizzo	----------	Present
	John H. Sanders	Present	Present
	A. B. Schneider, Jr.	Present	Present
	Frederick T. Suppes	Present	Present
	William V. Trowbridge	Present	Present
	Elden C. Weckesser	Present	Present
GEAUGA	Bruce F. Andreas	----------	Present
	Simon Ohanessian	Present	----------
LAKE	Joseph W. Koelliker, Jr.	Present	Present
	Robert A. Irvin	Present	Present
	SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	Present	Present
MAHONING	Joseph V. Newsome	Present	Present
	Jack Schreiber	Present	Present
	Charles W. Stertzbach	Present	Present
	Joseph W. Tandatnick	Present	Present
PORTAGE	Edward A. Webb	Present	Present
STARK	Aubrey R. Furnas, Jr.	Present	Present
	Mark G. Herbst	Present	Present
	Maurice F. Lieber	Present	Present
	William A. White, Jr.	Present	Present
SUMMIT	William Dorner, Jr.	Present	Present
	Thomas W. Jackson	Present	Present
	James W. Parks	Present	Present
	Leonard V. Phillips	Present	Present
	F. J. Waickman	Present	Present
	Robert E. Yeakley	Present	Present
TRUMBULL	Steven A. Pollis	Present	Present
	Rex K. Whiteman	Present	Present
	SEVENTH DISTRICT		
BELMONT	James F. Sutherland	Present	Present
CARROLL	Glenn C. Dowell	Present	Present
COSHOCTON	N. L. Wright	Present	Present
HARRISON	Elias Freeman	Present	Present
JEFFERSON	Sanford Press	Present	----------
	Crist G. Strovilas	----------	Present
MONROE	Byron Gillespie	----------	----------
TUSCARAWAS	R. E. Rinderknecht	Present	Present

County	Delegate	First Session	Second Session
	EIGHTH DISTRICT		
ATHENS	Don R. Johnson	Present	Present
FAIRFIELD	Jack L. Kraker	Present	Present
GUERNSEY	James A. L. Toland	Present	Present
LICKING	Jay R. Wells	Present	Present
MORGAN	Henry Bachman	----------	Present
MUSKINGUM	Carl E. Spragg	Present	Present
NOBLE	Edward G. Ditch	----------	----------
PERRY	Charles E. Bope	----------	----------
WASHINGTON	Kenneth E. Bennett	Present	Present
	NINTH DISTRICT		
GALLIA	Thomas W. Morgan	Present	Present
HOCKING	L. W. Starr	Present	----------
JACKSON	Clarence C. Fitzpatrick	Present	Present
LAWRENCE	Thomas E. Miller	----------	----------
MEIGS	Roger P. Daniels	Present	Present
PIKE	Mack E. Moore	----------	----------
SCIOTO	William M. Singleton	Present	Present
VINTON	Richard E. Bullock	----------	----------
	TENTH DISTRICT		
DELAWARE	Adelbert R. Callander	Present	----------
FAYETTE	Robert A. Heiny	----------	----------
FRANKLIN	Homer A. Anderson	Present	Present
	Norman H. Baker	Present	Present
	Joseph A. Bonta	Present	Present
	James C. Good	Present	Present
	Thomas M. Hughes	Present	Present
	William E. Hunt	Present	Present
	John R. Huston	Present	Present
	Charles W. Pavey	Present	Present
	D. W. Traphagen	Present	----------
KNOX	James C. McLarnan	Present	Present
MADISON	Sol Maggied	Present	Present
MORROW	Joseph P. Ingmire	Present	Present
PICKAWAY	Carlos Alvarez	----------	Present
	Jasper M. Hedges	Present	----------
ROSS	Lewis W. Coppel	Present	Present
UNION	E. J. Marsh	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	Charles H. McMullen	Present	Present
ERIE	Emil J. Meckstroth	Present	Present
HOLMES	Adam J. Earney	Present	Present
HURON	William R. Graham	Present	Present
LORAIN	Ben V. Myers	Present	Present
	James T. Stephens	Present	Present
MEDINA	Richard W. Avery	Present	Present
RICHLAND	H. F. Mills	Present	----------
	Carl M. Quick	Present	Present
	C. Shamess	----------	Present
WAYNE	Albert B. Huff	Present	Present
	OFFICERS		
President	Henry A. Crawford	Present	Present
President-Elect	Lawrence C. Meredith	Present	Present
Past President	Robert E. Tschantz	Present	Present
Treasurer	Phillip B. Hardymon	Present	Present
	COUNCILORS		
District			
FIRST	Robert E. Howard	Present	Present
SECOND	Theodore L. Light	Present	Present
THIRD	Frederick T. Merchant	Present	Present
FOURTH	Robert N. Smith	Present	Present
FIFTH	P. John Robechek	Present	Present
SIXTH	Edwin R. Westbrook	Present	Present
SEVENTH	Benjamin C. Diefenbach	Present	Present
EIGHTH	Robert C. Beardsley	Present	Present
NINTH	George N. Spears	----------	----------
TENTH	Richard L. Fulton	Present	Present
ELEVENTH	William R. Schultz	Present	Present
	Totals	157	151

President's Address . . .

Presented Before the OSMA House of Delegates at The 1966 Annual Meeting in Cleveland on May 24

By HENRY A. CRAWFORD, M.D., Cleveland

MEMBERS of this House of Delegates; Fellow Physicians: In my inaugural remarks one year ago, I declared that, as President of the Ohio State Medical Association, I had no intention of presiding over a wake for organized medicine.

This remark was prompted by the impending passage of Medicare, and the ensuing government medical program it provides.

I am proud to stand before you this evening and report that, rather than a wake, your OSMA and its 10,000 members have had a rejuvenation.

To the hand-wringing prophets of gloom and doom, I can say:

Never has our Association been stronger.

Never has our Association been more active.

Never has our State Association displayed more leadership . . . on both a state and a national level.

Never has the interest of our members been higher.

Never has their expression of support and cooperation been greater.

Never have so many of our Officers, Councilors, Committees, AMA Delegates and Alternates, and our County Medical Society officers worked so hard.

These superlatives do not reflect only my personal opinion. They are based on the scores of comments, remarks, letters, and phone calls I have received from enthusiastic members.

Before I go further, I want to pay tribute and give my own vote of appreciation to the executive staff of this Association, Hart Page, Chuck Edgar, Mike Traphagan, Herb Gillen, Gordon Moore, and Dr. Perry Ayres, the Editor of our *Journal,* along with the headquarters clerical staff of efficient secretaries and other workers. Without their loyalty and devotion to this organization, nothing could have been accomplished. Some of you may be aware that the executive staff is one man short and I surely hope a suitable addition can be made soon, so that our legislative program can go forward at an accelerated rate when the State Legislature meets this next year.

I would like to take this opportunity to thank my office associate, Dr. George Tischler, my secretary, Jocie Schweitzer, and my industrial nurse, Helen Sido, for covering my practice during the many days I have been away to meetings. Thanks should also be extended to my fellow staff members at Lutheran and St. Vincents Charity Hospitals for cutting my staff assignments and paper load during this rather busy year.

Now, I would like to touch briefly the high points of the past year, comment on the present and dwell on the future.

The Year in Review

In the past twelve months, your Council has held what surely must be a record number of meetings. Usually, Council meets about five times a year. In the past year, Council has met almost monthly, thus reflecting the large volume of matters to be transacted.

Here again, I would like to digress a minute and extend thanks from myself and the association to the members of The Council, committee chairmen, and committee members for attendance at many many meetings this past year. Here is where the interim policies are made and examined and passed on to The Council for implementation if they so desire. On very few occasions this year, if at all, has The Council failed to adopt the recommendations of these committees.

We have taken a number of sound, positive steps during the past year.

First, there was the adoption of the "usual customary and reasonable" fee program which we convinced the Bureau of Workmen's Compensation to be both feasible and fair.

This was a tremendous breakthrough. It represents a program where no government agency is dictating to physicians the value of their professional services.

In a majority of cases, this program is working smoothly. I regret to report that we have encountered some "bugs," but we are working to eliminate them. Also, it is our hope that this usual and customary fee plan can be expanded — regardless of how long it takes — to include all government medical care programs.

We are convinced that it can be expanded if all our members follow the guidelines recommended by Council and by this House of Delegates.

NOTE: For the report of the Committee on the President's Address, see page 698 in the official proceedings of the House of Delegates.

Statement of Policy

I call to your specific attention the policy regarding government medical care programs adopted by Council. This policy calls on all members to preserve the physician-patient relationship and the quality of medical care by billing the patients they accept under all such programs.

This statement received wide national publicity. It was prominently featured in *The AMA News*. It was distributed to all the other state associations. It has been adopted, word for word, by at least one other state association, and it has served as a guide for similar statements by several other state societies.

The statement was sent to all OSMA members, along with an article on hospital utilization commit-



Dr. Henry A. Crawford is shown here presenting "The President's Address" during the first session of the House of Delegates.

tees and a Bureau of Workmen's Compensation legal opinion, as Medicare Newsletter No. 3.

The legal opinion also represents a landmark. It stated that the Bureau could not legally "make payments to a hospital where it is known that there is a fee-splitting arrangement between the hospital and a roentgenologist."

Ohioan Honored

OSMA was honored this past year by the election of one of our Past Presidents, Charles L. Hudson, to the office of AMA President-Elect. Dr. Hudson will be installed in medicine's highest office next month at the AMA Annual Convention.

You would have been pleased and proud of the leadership and dedication of your OSMA delegation to the AMA at the 1965 Clinical Convention in Philadelphia. Under the chairmanship of Dr. John Budd, your delegates fought for and won adherence to principles and positions that best reflect the policies established by this OSMA House of Delegates.

Your Council has directed your AMA delegation to nominate Dr. Budd, at next month's annual convention, for the important office of Vice-Speaker of the AMA House of Delegates. The respect and stature Dr. Budd holds in the AMA House has prompted many other states to recommend that we make him a candidate. We are proud to do so, and we are certain of victory.

On the housekeeping side, we have relocated our headquarters facilities. While we do not occupy a great deal more office space, we do have a more efficent, more functional and more attractive headquarters. This move was long overdue, and I am pleased to report that it has been accomplished.

Your OSMA has assisted, and supported at every opportunity, the efforts of certain medical specialty groups to rid themselves of the threatened domination of their practice by hospitals. I can assure you that we will continue this mission, just as we will assist and support with every ounce of our energy any threat to dominate and control any segment of the medical profession.

We were highly pleased and impressed by the outstanding attendance at, and participation in, our District Conferences last fall for County Medical Society officers and key committee chairmen. We enjoyed the same attendance and participation in our 1966 County Medical Society Officers Conference in Columbus.

We are pleased to announce the organization of the Ohio Association of County Medical Society Executives. These persons, by sharing knowledge, experiences and ideas, can reinforce their efforts to assist the County Societies they so capably represent. Seventeen County Societies in Ohio now have executive secretaries.

I suggest that some of the nonmetropolitan County Societies consider the idea of sharing an executive secretary with two or three other counties, or perhaps on a Councilor District basis. The increasing number of Medical Society programs, projects, interest and demands make this well worth your serious consideration.

A Look at the Present

Enough of the past. Now, let me touch on the present before I look to the future.

Another concrete example of our members' strong interest in OSMA, in what we say and what we do as a medical organization, is found in the delegate's packet which you have before you. I refer specifically to what I believe is the record number of resolutions which the County Societies have indicated they will present here tonight for your consideration and action.

You are honored to be here, for I feel that it is an honor for any man when his fellow physicians select and elect him to represent them in deciding what is best for medicine and best for the patients medicine serves.

I know that, in this spirit, you will consider these resolutions before the Reference Committees tomor-

row and act on them Friday morning. In this same spirit, you will elect your Officers, Councilors, Delegates and Alternates.

Distinguished Leaders

Before turning to the future, I want to point out that we are honored by having three distinguished medical leaders participating in our 1966 Annual Meeting.

One is my fellow Clevelander who will be installed as President of the AMA just five weeks from this date — Dr. Charles L. Hudson.

Another is an outstanding Past President of the AMA who will address our meeting Friday morning — Dr. Edward R. Annis, of Miami, Florida.

The third is a man who has done more for Ohio medicine than any physician I know . . . a man whose life has been given to upholding and preserving the ideals, principles and ethics of our profession . . . the man to whom we humbly dedicate this 1966 Annual Meeting, Dr. Herbert M. Platter.

The New Look in Medicine

The theme of this meeting is **The New Look in Medicine.** In turning now to the future, I must, in all sincerity, not only ask, but warn that we must take on a "New Look."

The atmosphere in which we practice is taking on a new look. We must adjust . . . we must adapt . . . and we must dedicate ourselves to the task of meeting this new look . . . these new conditions and responsibilities that confront us.

Instead of asking, "What do we face?" I am going to state . . . emphatically and unequivocally . . . what we **must** face.

We must face up to the fact that the privileges of our profession . . . privileges we have earned . . . carry equal responsibilities. We must shoulder these responsibilities.

These are medical responsibilities. If they are not shouldered by medical men, then we immediately will find them being taken over by nonmedical interests . . . interests that do not look on our patients as people . . . as human beings . . . but, rather, look on them as collective numbers.

As individual physicians, we cannot delegate our responsibilities to our County Medical Society . . . our Ohio State Medical Association . . . or the American Medical Association. We cannot legislate in convention this week, then go home and forget about it for another year. We are running out of years . . . out of months . . . even out of days.

We are approaching medicine's moment of truth. It is entirely within our hands to determine whether this becomes a period of darkness or becomes medicine's finest hour.

Importance of Committees

One responsibility is that of our Medical Society review or mediation committees. A good example is the usual and customary fee program of the Bureau of Workmen's Compensation.

I am happy to report that most committees are doing an excellent, effective job in reviewing cases which the Bureau has questioned. Unfortunately, I regret to say that some committees are failing to meet their responsibilities. The proof is found in files in our OSMA headquarters.

These committees must realize that they cannot bow to the whims of one person. They must consider the whole picture . . . the whole spectrum of medicine.

I think it is ridiculous . . . downright short-sighted . . . to oppose effective review committees. I would much rather be judged by my fellow physicians in medical matters than be judged by some lay claims clerk who doesn't know a hypodermic from a hydrocele.

Review committees of all kinds function with conviction . . . with impartiality . . . regardless of what parties may be involved. They must base their recommendations on fact . . . not fear or fancy. They must not only know and understand the *Principles of Medical Ethics,* but they must uphold these principles.

This applies to all matters brought before such committees, and not just workmen's compensation cases. However, I must dwell on these industrial cases because of the current situation.

The burden of proof is on us. The burden of proof is on the OSMA, the County Society and the individual physician . . . to prove that this program can work . . . can succeed . . . and can best serve all interests involved.

Your OSMA fought hard to achieve what was said to be impossible. Your OSMA convinced the Bureau of Workmen's Compensation that this program could succeed, just as the Ohio Medical Indemnity usual and customary fee plan is succeeding. Now, it's up to you. If you want to preserve it, fight for it.

Improved Medical Practice Act

Another responsibility we must face in the near future is the strengthening and improvement of the Ohio Medical Practice Act. Your OSMA intends to seek badly needed . . . and too long delayed . . . legislation to improve this Act.

The present Act has too many weaknesses. It does not give the Medical Board the authority to give to the citizens of Ohio the protection they need. The legislation we will seek must protect . . . effectively . . . our citizens against the medical charlatan, the quack, the incompetent.

I charge you members of this House to return to your communities and immediately enlist the support of your fellow physicians, your fellow citizens and your State Representatives and Senators to assure passage of this vital measure.

A Policy — A Stand

One of the responsibilities we shirk so miserably is that of informing ourselves and supporting the actions, statements, and policies of this Association.

I refer, as an outstanding example, to the Policy Statement of The Council of the Ohio State Medical Association Regarding Government Medical Care Programs," adopted by Council, March 20, 1966.

For months, members had been saying to your state officers and your Councilors, "What is OSMA going to do about Medicare?" "What can it do?" "How will Medicare change my practice?"

Council's statement was sent, in Medicare Newsletter No. 3, to all OSMA members. Also, it was sent to the AMA, to all other State Associations and to all specialty societies.

I am pleased to report that this statement was adopted verbatim by at least one other State Association, and has been used as a guide by other State Associations in developing their own statements.

We have received, from coast to coast, numerous requests from medical organizations for additional copies of this statement . . . asking for 25 copies to 1,000.

But most of our own members couldn't be bothered to take the time to read it. If most of our County Medical Society officers read it, they apparently failed to recognize its significance.

These are harsh words. They are true words. Proof is found in reports I have had from Councilors after they attended County Society meetings. These meetings were to discuss Medicare. "What to do? How will we bill? How will we be paid?" . . . Those were some of the questions doctors asked at these meetings.

Why a Policy?

This policy statement of The Council was developed for three purposes:

First . . . to put this Association officially on record.

Second . . . to recommend policy to the County Societies.

Third . . . to give the individual members of this Association guidelines for conducting medical practice under **all** government programs.

Gentlemen, this statement of policy was Ohio Medicine's 1966 Declaration of Independence. If our County Societies and our individual members do not support it . . . and support it forcefully . . . it becomes empty words on paper.

We will include this statement in the next *OSMA-gram.* I urge you, in meetings of your County Societies, to study this statement, to support it, and to urge your members to adhere to it in the personal conduct of their practice.

Another area of concern is the field of postgraduate education. We physicians are finding it more and more difficult to find time to keep abreast of medical progress. We are finding it more and more difficult to find postgraduate courses that are practical rather than theoretical.

We must improve the availability, the content and the quality of these courses. We must establish a closer working relationship with our medical schools and other medical centers to accomplish this task.

To accomplish it, we must continually impress on our medical schools and our medical educators the cold, hard fact that their primary mission . . . their first obligation to the profession and to the public . . . is **medical education . . .** not research.

Where Responsibility Lies

Too many physicians are forgetting personal service to patients. Too many are allowing third parties to handle responsibilities that should be handled by the physician and the patient.

We must combat the public's false impression that we are more interested in organs and diseases than we are in people.

We must combat the public's erroneous attitude that we are more interested in recreation and travel than we are in patients.

We must re-establish in the mind of the public, awareness of the hard fact that . . . as physicians . . . we devote the major portion of our time . . . our energies . . . our lives . . . to meeting . . . to the best of our abilities and our efforts . . . the solemn responsibility of caring for the health and well-being of our patients.

After a year in the office I will soon relinquish . . . after traveling 75,000 miles . . . after a thousand meetings . . . and with hundreds of new friendships . . . I want to thank this House of Delegates . . . humbly and sincerely . . . for the privilege of sharing in so many rich and rewarding experiences.

Only those who have preceded me in this office can understand and appreciate my deep, personal feelings on this occasion.

Points to Remember

In summary and as a conclusion let us:

1. Keep the "pot" boiling, keep up the steam. I am sure that Larry Meredith and his officers and staff can keep the lid on, letting off the pressure here and there.

2. Keep up the communicating to the County Societies and to individual members, and never quit applying the pressure on the AMA to heed the voices and warnings from the grass roots.

3. Record and document all the inefficiencies, the mistakes and the boondoggling under governmental and other such programs, that deteriorate the quality of medical care given our patients; and then let us cry out in loud and distinct tones to the people about such practices and participate in correcting or abolishing them.

4. Handle our own "dirty linen," and work dili-

gently for laws and other measures to eliminate unethical and incompetent practice.

5. Make every effort to establish a practical means of postgraduate education so as to maintain each doctor's fund of knowledge current that our patients may benefit from the latest treatment and medications.

6. Organize a study group or a committee or "what not" to keep our associations abreast of the latest socio-economic thinking of the welfare agencies, "do gooders," labor unions and others so that we can counter these before politicians can take control of all medicine.

7. Actively participate in community activities, politics at all levels, and campaigns such as water and air pollution.

There are many more activities we could think of, so add as many as you want so long as you work at their correction.

One last thought. I remember reading this statement on the Warner and Swasey billboard at East 55th and Carnegie several years ago.

"Only the strong remain free." I repeat, "Only the strong remain free."

Let us heed this warning.

Outstanding Scientific Exhibits At Annual Meeting Awarded

A JUDGING committee designated seven Scientific Exhibits at the 1966 OSMA Annual Meeting in Cleveland to receive special recognition and their sponsors were presented awards. They were among 27 Scientific Exhibits presented in the area where Health Education Exhibits and Technical Exhibits were on display.

Annual Meeting planners have authorized a monetary award as well as a permanent type, mounted metal plaque and certificate for each exhibit judged as outstanding. Following are the authorized awards with the names of selected exhibits and their sponsors:

Gold Award in Teaching: The exhibit, "Control of Hemorrhage by G-Suit," sponsored by Drs. John Storer and James Gardner, of Huron Road Hospital, Cleveland.

Gold Award in Original Investigation: The exhibit, "Stereoscopic Microangiography: Observations on the Microcirculation in Bone Repair," sponsored by Drs. F. W. Rhinelander, R. S. Phillips, and W. M. Steel, Western Reserve University School of Medicine and Cleveland Metropolitan General Hospital, Cleveland.

Silver Award in Teaching: The exhibit, "Simplified Treatment of Breast Cancer," sponsored by Drs. George Crile, Jr., and C. B. Esselstyn, of the Cleveland Clinic.

Silver Award in Original Investigation: The exhibit, "Bilateral Transabdominal, Transperitoneal Omentoureterostomy," sponsored by Dr. Arthur A. Roth, Cleveland.

Bronze Award in Teaching: The exhibit, "Office Evaluation of a Geriatric Patient," sponsored by the following team from the Ohio Department of Health, in cooperation with the USPHS Gerentology Branch, Columbus: Dr. Emmett W. Arnold, Ohio director of health; Dr. Aileen L. MacKenzie; Frances Williamson, Richard W. Orzechowski, and Dennis Webb.

Bronze Award in Original Investigation: The exhibit, "Let's Control Rubella in Ohio," sponsored by Dr. Gilbert M. Schiff, University of Cincinnati College of Medicine.

Special Award: The exhibit, "Motorbike Safety," sponsored by the following team of the Committee on Trauma of the Academy of Medicine of Cleveland: Drs. R. C. Waltz, Karl Alfred, Vernon Hacker, J. D. Osmond, and George Phalen.

Series on Outstanding Exhibits To Be Published in Journal

Because of the obvious educational value of the Scientific Exhibits, and for the further purpose of bringing to its readers additional information on the material presented, *The Journal* will publish a series of special articles on the seven exhibits judged as outstanding. This tribute is in keeping with a policy established by the Committee on Scientific Work, and approved by The Council.

Watch for the coming issues of *The Journal* and illustrated features about exhibits listed on this page. Through this means, *The Journal* not only will salute the outstanding exhibits, but will attempt to acknowledge the many hours of research and preparation all of the sponsors have put behind their presentations.

Inaugural Address ...

More Challenging Role for the Medical Profession's Potential Strength Is Urged by Incoming President

By LAWRENCE C. MEREDITH, M. D., Elyria

IN THIS 1966 session of the House of Delegates, we have been privileged to be the participants simultaneously in the end of two eras. We have justly acclaimed the long career, and have expressed our sincere admiration for Doctor Herb Platter's contributions to medicine in Ohio. In a grave sense of privilege as members of this House of Delegates, we find ourselves, against our will, participants in the end of another era . . . this being the final session of the House before Medicare.

No one here today is vested with power to predict accurately the impact of Public Law 89-97 upon the profession or upon society. We can anticipate that there will be abundant evidence of the effect of this law upon the spirit with which we will reassemble in May, 1967.

The end of an era is but the beginning of another. The medical profession has faced many eras. It has created change, and it has led change.

As a leader, the medical profession has evolved statements of principle, of purpose, of rule and ethics which today insure the highest quality of professional relationship. I am confident that, through medicine's voluntary "self-policing, self-determination, and self-evaluation," Ohio physicians ensure the best of medical care for the patients of Ohio.

A year from now, if our spirit and dedication for leadership are to match and continue that of our medical predecessors, we must at that time assess our weaknesses, our strengths and plan realistically for future action.

Are We 10,000 Strong?

OSMA membership is now 10,000. But are we 10,000 strong?

I have observed many attitudes which lead me to wonder, at this turning point, if Ohio physicians have faith in, or recognize the strength of our organization.

Many physicians have said: "We are lost! There is no future in the voluntary practice of medicine!" In the doctors' dressing room at the hospital, many are quick to criticize medicine's shortcomings. But these men will not speak out in a County Society meeting; others will not participate in County Society activities because they are "too busy" with patients, or are too busy with hospital staff commitments.

Are we 10,000 strong, if, in some County Society meetings, announcements of state or national problems or policy are ignored in favor of long-winded guest speakers?

Strength — or Weakness?

What of the strength of our principles if 4,000 physicians signed the exculpatory Civil Rights oath? And what strength have we if only 2,900 in Ohio joined OMPAC and AMPAC?

Here we stand at the beginning of an era with the federal "foot in the door." We are strong in number, but through fatalism, perhaps indifference, and hampered by faulty communication, we have some glaring weaknesses.

At this turning point, we cannot blame the past for that "foot." The call for physicians to stand in support of their traditions and ethics is clear! We must answer this call in growing unity, sophistication, and, above all, courage.

Unity can only evolve if individual members recognize their common heritage as doctors of medicine. All physicians must realize that, despite the increasing fragmentation into specialties, each, contributing of himself in a dual role of physician and citizen, strengthens the organization. In this coming year we must explore mandatory indoctrination of new physicians as a requirement for active membership in County Society and State Association.

Matters of Ethics

Section Four of the *Principles of Medical Ethics* states: "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity of the profession, and accept its self-imposed disciplines. They should expose without hesitation, illegal or unethical conduct of fellow members of the profession." We must in this coming year explore methods of educating our component societies in the legal mechanics of the self-regulatory and self-disciplinary procedures as outlined in our Bylaws.

Presented before the House of Delegates at the OSMA Annual Meeting in Cleveland, May 27, 1966.

Organizational unity cannot be increased without a more equitable representation from our component societies. Council and the House of Delegates last acted upon this problem in 1939, with the establishment of the Eleventh District. District lines may have to be changed. Perhaps another district must be evolved.

We must also, in our effort to gain greater unity, acknowledge the growth and participation of Specialty Sections. I believe, that acting in accordance with our Bylaws, delegate representation from Specialty Sections could be evolved.

A Call for Knowledgeability

The call for unity without knowledgeability of variation of usual, customary, and reasonable fees, or without knowledge of hospital utilization patterns throughout the state, is pointless. From a political point of view, Congress, in establishing P. L. 89-97, has placed reliance on existing mechanisms and procedures established by the state and local societies for determining reasonable charge. We may place our organization in joepardy if we are not so knowledgeable. From an educational as well as a political point of view, the Association must have current and reliable facts concerning utilization or face the strong possibility of external regulation which truly may lead to the deterioration of the voluntary practice of medicine.

It is a paradox that we daily contribute such data to hospitals and third parties, but are too penurious or naive to assemble these facts for our own education or protection.

We must, then, explore in this coming year sophisticated methods of collecting, analyzing, and using such data if we are to support the principles we have enunciated in the past, or to support the actions we have taken in this House of Delegates.

Positive Leadership

Unity and sophistication, however, cannot turn the tide of battle. If the medical profession is dedicated to leadership, we must have the courage to lead! The most biting criticism of our profession has been that we are "against" and never "for." We have in this session shown that we are for improvement in mental health, for betterment of air and traffic safety, for betterment of the health of the migrant worker and the hard of hearing. But, in none of the 47 resolutions have we been for a courageous stand in opposition to the one element in P. L. 89-97 which in my mind places, through economic threat of that law, the possibility of seeing not only the "foot" but the "whole leg" through the door. That element is the granting of "want" not "need" in this legislation. Therefore I charge myself, and Council, and this House of Delegates, and every member of OSMA, to be courageous in this coming year, to study actively and attempt to formulate recommendations that will



Dr. Lawrence C. Meredith is shown here addressing the second session of the House of Delegates immediately after being installed as President for the coming year.

provide continuing protection to the relationship of patient and physician.

Finally, essential to the spirit with which we face this new era must be the recognition that no one physician, no one medical staff, no one society, no one school of medicine can speak for the profession. The voice that speaks must be the composite of all. It whispers if we fail to communicate with each other.

We of this House of Delegates will reassemble in 1967 with the deep conviction that only the Ohio physician intimately knowledgeable of his community provides, and will in growing unity, sophistication, and courage, continue to fight for the high quality of medical care long enjoyed by the Ohio patient!

Drug Firm Foundation Promotes Career Selection Program

Twenty-nine students from 24 colleges and universities in Ohio and Pennsylvania have been chosen by their schools to participate in a summer program designed to help them decide on medical careers.

The college men and women are taking part in the Medical Careers Program of the Smith Kline & French Foundation, scientific and educational trust of the Philadelphia-based prescription drug firm. Each student will work for eight to 12 weeks at one of the medical schools on research projects along side medical students and with supervision of physicians.

Six students of Ohio colleges are assigned to Western Reserve University School of Medicine. They are Lawrence Barnthouse, Kenyon College Sophomore; Wayne Beveridge, Kenyon College junior; John M. Moorhead, Ohio Wesleyan University sophomore; Julia Pfile, Oberlin College sophomore; Gregory Prazar, Wooster College junior; and James Whipple, Baldwin Wallace College sophomore.

Annual Meeting Attendance ...

Tabulation Shows Number of Members and Guests Who Attended, with Comparative Figures for Other Years

REGISTRATION records for the 1966 Annual Meeting in Cleveland, May 24-28, show that both members of the Association and guests attended excellent numbers. Total registration was 3035, with the following breakdown: Members, 1484; guest physicians, 309; medical students, 22; Woman's Auxiliary, nurses, dentists, technicians, and miscellaneous guests, 865; scientific and technical exhibitors, 355.

Following are registration figures for members of the Association by counties and a comparison of Annual Meeting attendance figures from 1919 through 1966:

Registration by Counties, 1966 Annual Meeting, and Membership Data

County	Total Membership Dec. 31, 1965	Total Membership May 18, 1966	Ann. Meet. Registration
Adams	14	13	2
Allen	124	124	14
Ashland	25	26	7
Ashtabula	59	59	9
Athens	37	37	4
Auglaize	16	16	3
Belmont	55	54	8
Brown	15	14	1
Butler	174	175	9
Carroll	10	10	2
Champaign	17	17	1
Clark	128	124	10
Clermont	28	26	3
Clinton	22	21	1
Columbiana	67	68	11
Coshocton	25	24	5
Crawford	39	40	6
Cuyahoga	2315	2219	630
Darke	24	24	6
Defiance	21	20	3
Delaware	27	26	5
Erie	67	64	10
Fairfield	53	50	8
Fayette	16	16	0
Franklin	928	868	127
Fulton	17	16	1
Gallia	33	33	3
Geauga	24	26	7
Greene	49	52	7
Guernsey	29	25	7
Hamilton	1243	1223	66
Hancock	47	48	6
Hardin	26	26	1
Harrison	7	7	2
Henry	15	16	2
Highland	19	18	2
Hocking	9	8	3
Holmes	10	10	5
Huron	28	26	5
Jackson	16	15	2
Jefferson	63	39	5
Knox	36	37	5
Lake	108	107	31
Lawrence	22	22	1
Licking	69	67	6
Logan	18	15	1
Lorain	193	194	35
Lucas	613	584	48
Madison	14	14	5
Mahoning	336	337	31
Marion	66	66	5
Medina	57	56	9
Meigs	6	6	1
Mercer	21	18	4
Miami	62	66	5
Monroe	3	3	0
Montgomery	579	539	36
Morgan	3	2	2
Morrow	8	8	2
Muskingum	73	72	10
Noble	2	2	0
Ottawa	23	23	3
Paulding	7	7	1
Perry	10	9	1
Pickaway	17	19	3
Pike	11	10	0
Portage	55	56	9
Preble	11	9	1
Putnam	12	11	2
Richland	119	118	21
Ross	39	39	7
Sandusky	46	46	4
Scioto	68	67	13
Seneca	45	44	8
Shelby	22	22	2
Stark	354	346	44
Summit	572	556	55
Trumbull	134	132	15
Tuscarawas	51	52	18
Union	18	18	4
Van Wert	20	21	2
Vinton	1		0
Warren	16	14	2
Washington	30	30	6
Wayne	60	59	9
Williams	18	18	3
Wood	42	38	3
Wyandot	11	11	2
Total	10,042	9713	1484

ANNUAL MEETING REGISTRATION FOR 1919 - 1966 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with AMA						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035

The Annual Meeting in Review ...

Here Are Some Highlights and Sidelights on Events That Combined To Make Another Successful Session

THIS review is an attempt to pinpoint only a few of the many events and functions that are typical of the 1966 Annual Meeting and that helped make it another successful meeting for members and guests. Obviously only a few of the highlights and sidelights can be touched upon with a hint of special meetings, luncheons, dinners, social hours, hospitality groups, reunions, and a host of other get-togethers.

Elsewhere in this issue are a presentation of the newly elected Officers and Councilors, official proceedings of the House of Delegates, the President's Address, and the Inaugural Address of the Incoming President, an official tabulation of the attendance record, report from the Woman's Auxiliary, etc.

Official Hosts

Dr. David Fishman, Cleveland, president of the Academy of Medicine of Cleveland and Cuyahoga County, officially opened the House of Delegates 1966 sessions and welcomed Association members and guests to Cleveland.

A great deal of the success of the meeting and the comfort of guests was due to efforts on the part of numerous members of local committees who worked primarily behind the scenes in preparations for events.

Guests from Other States

Among distinguished guests from neighboring states were Dr. Seigle W. Parks, Charleston, president of the West Virginia State Medical Association; Dr. James S. Klumpp, Huntington, past president of the West Virginia State Medical Association; Dr. William B. West, Huntingdon, Pa., president of the Pennsylvania Medical Society; Dr. Donald K. Dudderar, Newport, Ky., vice-president of the Kentucky Medical Association; Dr. Luther R. Leader, Royal Oak, Mich., president of the Michigan State Medical Society; Dr. Kenneth O. Neumann, Lafayette, Ind., president of the Indiana State Medical Association.

Another guest was Dr. Thomas L. Dwyer, Mexico, Missouri, president of the American Association of Physicians and Surgeons. In addition, a number of out-of-state guest physicians participated in the pro-

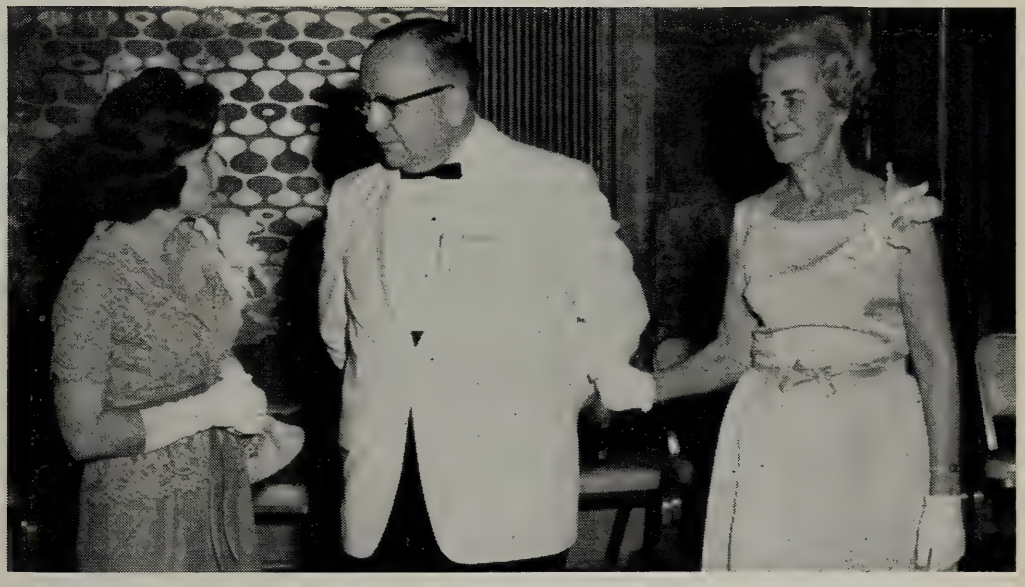


Typical of the General Sessions is this audience in the Cleveland Room photographed on Wednesday afternoon during the program on "Marriage Problems."

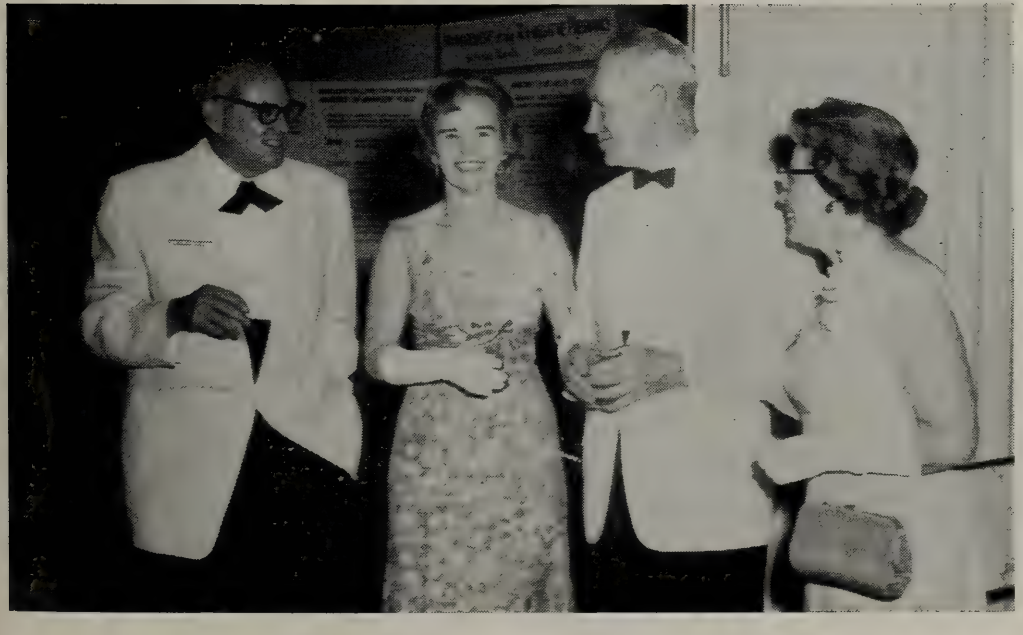
Camera Highlights of the Meeting



In the receiving line at the President's Reception, from left: Dr. Robert E. Howard, New President-Elect, Mrs. Howard, Dr. Lawrence C. Meredith, Incoming President. In background Charles W. Edgar, OSMA Public Relations Director



Mrs. Meredith Dr. Henry A. Crawford, 1965-1966 President, Mrs. Crawford



Dr. Philip B. Hardymon, Treasurer, Mrs. Hardymon, Dr. Robert E. Tschantz, Immediate Past President, Mrs. Tschantz

grams indicated by names and portraits printed in the official program.

OMPAC - AMPAC Luncheon

Highly successful event held during the Annual Meeting was the luncheon sponsored by the Ohio Medical Political Action Committee and the American Medical Political Action Committee on Wednesday.

Principal speaker for the occasion was Dr. Hoyt D. Gardner, Louisville, Ky., a member of the Board of Directors of AMPAC, who inspired his audience with the topic, "Success Can Be Ours."

Dr. Platter Honored

By official action of the House of Delegates, the entire 1966 OSMA Annual Meeting was dedicated to Dr. Herbert M. Platter, Past President of the State Association, and Secretary of the State Medical Board of Ohio from 1917 through 1965. See Resolution No. 1, page 696 of this issue.

A standing ovation was accorded Dr. Platter at the first session of the House of Delegates and President Crawford presented him with a copy of the resolution inscribed in bronze expressing the admiration and gratitude of the physicians of Ohio for his outstanding leadership, guidance and counsel. He also was presented a color television set as a token of appreciation from the Association.

Dr. Platter acknowledged the honor with brief remarks to the House. Now making his home at the Lutheran Senior City in Columbus, Dr. Platter celebrated his 97th birthday on June 18. He was accompanied to the Cleveland meeting by his son and and daughter-in-law, Mr. and Mrs. Harold O. Platter, of Columbus.

Lieutenant Governor Brown

Representing the State of Ohio in honors to Dr. Platter was Lieutenant Governor John W. Brown who brought greetings and a special message from Governor Rhodes. He also paid personal tribute to Dr. Platter for the many services he has rendered to the people of Ohio.

Past Presidents Honored

A reception and dinner was given by The Council on Wednesday evening of the Annual Meeting week honoring Past Presidents of the Association. Each Past President was presented a plaque as a token of appreciation for his services to the Association. See photograph of Past Presidents elsewhere in this issue.

News Media Coverage

News media coverage of the meeting reached what many believed to be an all-time high. Press, radio, and television reporting of the meeting was extensive, and several presentations were reported on TV network newscasts.

In addition, several national medical journals had writers covering the meeting.

The Woman's Auxiliary

The Woman's Auxiliary to OSMA again held its annual meeting concurrently with that of the Association. The numerous projects and functions of this organization, and the dedication of the ladies in positions of responsibility, are an inspiration to all persons interested in good medicine and health in Ohio. Refer to the report made before the House of Delegates by the Auxiliary president, beginning on page 729, and the account of the Auxiliary meeting written by the Auxiliary's correspondent begining on page 739.

Committeemen Named

Within the organization of the OSMA are numerous committees whose members work primarily behind the scenes on numerous projects, both scientific and organizational. Some of these committees are appointed by the House of Delegates and others are named by the President with the approval of The Council. Turn to the back of this issue and see the roster of committeemen beginning on page 746.



This is part of the large group of people who attended the OMPAC-AMPAC luncheon held in the spacious Gold Room.

The Woman's Auxiliary Report...

Auxiliary's President Gives Account of Year's Activities Before the OSMA House of Delegates Session, May 24, 1966

By MRS. HERBERT F. VAN EPPS, Dover

IT IS A PRIVILEGE to be granted a little time to tell you what our County Auxiliaries have been doing this past year when I know there are very important problems you are anxious to solve. It is not necessarily true that I am long winded, but our members have worked so hard all year in so many activities, there is much for me to report.

We greatly appreciate the cooperation and encouragement given by Dr. Crawford, our advisors and the staff at the Ohio State Medical Association office. Dr. Diefenbach, Dr. Beardsley and Dr. Light were never too busy to give advice or to listen to our problems. While our work on Medicare has lessened this year, we have had other important projects.

The Auxiliaries were asked to study the health needs of their counties, analyzing the strong and weak points. In planning their year's projects and programs, they were to work on their county needs. A poem from the Virginia Health Bulletin *Prevention and Cure* describes what happened.

'Twas a dangerous cliff, as they freely confessed,
Tho' the walk near its crest was so pleasant;
But over its terrible edge had slipped
A duke and full many a peasant.
So the people said, "Something would have to be done."
But their projects did not all tally.
Some said, "Put a fence around the edge of the cliff."
Some: "An ambulance in the valley."

AMA-ERF

Forty-eight of our 56 organized counties sent contributions into the AMA-ERF. These donations varied from $10 to $5325, for a total of $33,115.49. This is less than the total of $36,000 given at the end of last year. We are hoping this gap will be closed by our deadline. This money came from doctors' donations to their medical schools through the Auxiliary; sale of Christmas cards, donations sent to AMA-ERF instead of sending cards to doctors' families. One card was sent with the names of all the contributors. Other funds were raised by auction sales, some auctioning articles made by doctors, their families and friends. We are not aware of the talents in our midst until we see their art on display. There were bridge parties, the sale of sympathy and congratulation cards, and other articles — you name it, one of our auxiliaries sold it.

Our Legislation Chairman, Frankie Fry, in Cincinnati, has been a ball of fire all year — no let down because of Medicare. She sent bulletins out to all counties explaining legislation in the making, telling what should be done and what resulted. She is assisting counties in organizing nonpartisan Political Action Workshops, having supervised a couple of very successful ones in her own city. You will hear more of this work during the coming year, in both large and small counties.

Emphasis on Local Needs

Reports show that the county auxiliaries are working on the needs of their localities. Cincinnati with its project "The Apple Tree," a non-profit child day care center for children of key hospital personnel, has resulted in supplying over 8000 nursing and health work hours to nine hospitals. Stark County received the Golden Key Award from United Fund for the work of three women.

Cuyahoga County received the 1965 Second Place in the Mayor's Award Program for work in Traffic Hazard Elimination. The "Operation Know How" — disaster control — carried on in Cleveland had the assistance of that auxiliary. Members in most counties have sponsored Health Career days and Future Health Career Clubs. A total of $32,606 was given by the counties for Scholarships and Loans for Health Careers. This is money earned by Auxiliary members above the AMA-ERF funds. The counties have cooperated with Safety Councils. Safety attention was directed toward poison control, tetanus immunizations, seat belts, home, water and bicycle safety, mouth-to-mouth resuscitation, and traffic problems.

Other auxiliary energies were directed toward: S.S. Hope, packing supplies and drugs from your office samples, bandages, and eye glasses for international needs; volunteer hours to the mentally ill, and measles inoculations.

Have you been reading Ruth Meltzer's pages in your *Journal* on our events? If you haven't read them, look for them when you go home, for Ruth is a talented writer. The Auxiliary News, edited by Ludel Sauvageot, is also well worth taking your time to read. The $1500 received from the Ohio State Medical Association has been used to help publish this. The magazine is second to no other of the 50 state publications.

These are some of the contributions your wives are making to the medical profession. It shows our

wholehearted interest and our pride in the work you are doing for the betterment of humanity.

During our coming meetings we are asking our delegates to grant a raise in our State dues from $1.25 to $3.00 a year per member. We shall soon know the results.

Along with all the accomplishments of which we are so proud, there always has to be a little irritation. The OSMA has 10,042 membership, the Auxiliary 5,561. Where are those thousands of potential auxiliary members? We have 56 organized counties; 32 counties with no auxiliary. We have only 67 members-at-large from these counties. You will agree with me, I am sure, there is no woman's organization doing more worthwhile work than we are. I know all of your wives are members but you must know of other doctors' wives who should join. We are counting on your assistance.

A quote from the Bible expresses our situation so completely. "The harvest is plenteous, but the laborers are few."

Inasmuch as you have married us, you are stuck with us. Whether it is good or bad is not the point. The point is for you to make the best of what you have. Invite your auxiliaries to assist you on your projects, show them you are interested in them, and you will be amazed at the results. Your "better-halves" will never be happier than when they are feeling needed.

In a few days our very capable president-elect, Ruth Wychgel, of Cleveland, will take over the presidency of the State Auxiliary. She is planning a very active year and will appreciate your assistance and cooperation.

Thank you for allowing me to tell you of our accomplishments this year. May the coming year bring a closer relationship between our two organizations as we work together for Better Medicine.

Department Chairman Named At Western Reserve

Dr. John Robert Carter, professor and chairman of the Department of Pathology and Oncology at the University of Kansas Medical Center, will come to Cleveland some time before September 1. He has been named director of the Institute of Pathology and professor and director of the Department of Pathology in the Schools of Medicine and Dentistry at Western Reserve University. The posts were formerly held by Dr. Alan R. Moritz who became provost of WRU last September.

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The OSMA Section for Directors Of Medical Education

By WARREN G. HARDING II, M. D., Administrator
Grant Hospital, Columbus, Ohio

THE establishment of an Ohio State Medical Association Section for Directors of Medical Education is recognition of the changing factors in the concept of medical education. The diploma, internship, licensure and practice are valid accomplishments and essential, but the quality of medical care offered to the people of Ohio can be maintained only if the profession supports a continuing program of learning, extending throughout the physicians professional life. The environment of the learning situation changes from the schoolroom to the active direction of patient care, but the need for knowledge and research remains critical, if the doctor does not wish to become obsolete.

The emerging position of Hospital Director of Medical Education seeks to fill this need. The activities of the medical profession are focusing on the hospital to a greater degree each year. Many of the new technics require the controlled environment of the hospital with its medical and paramedical personnel in order to be effective. The Director of Medical Education is responsible to coordinate an additional program within the hospital so that practicing physicians can keep current without expending an excessive amount of energy and time to maintain their competence.

Why a New Section?

The question arises, "Why a new section in organized medicine?" What type of program is suitable for this group? What is the need? The answer to these questions could fill a volume. The present effort is to give a succinct outline of the direction of development which can be anticipated. The adjective flexibility is perhaps the most appropriate descriptive term. The involvement in the entire future of medicine requires an open course associated with creative ideas and a willingness to experiment.

This new section will be a forum for the discussion of organized medicine as it relates to the individual physician. The recent graduates need guidance in the aims, methods and structure of medicine, which in most cases, has not been made a vital part of their formal training. How can the medical association help them and they, in turn, add strength to their representative? The Director of Medical Education is closest to them in the early hospital experience. He must be informed and dedicated to medicine in its broadest aspect. His position lends itself to the continuing promotion of organized medicine for all physicians. The need is obvious for a statewide voice in the discussion and interpretation of the multitude of regulations, rules, opinions and edicts that the federal government, state and local government are continuously promulgating, which affect the practice of medicine.

Scope of Program

The program is limitless. Authentic information on staff relations, hospital administration, efficient methods of teaching, socio-economic problems as related to practice, community needs at both state and local levels, medico legal problems, information storage and retrieval, research methods applicable to clinical problems, cultural knowledge as seen in the humanities and detailed expertise required in transmitting these concepts to house staff and the practicing profession, provide an abundance of topics for the new section. In addition, the section should become a repository where authentic material may be found to facilitate the successful presentation of the many programs in the hospital for which the Director of Medical Education is held responsible. It is impossible for each one to complete individually the necessary research for these teaching efforts but through sharing with the others, the quality of the training effort can be greatly improved.

Encompassing Broad Field

The objectives of the new section encompass the entire field of medicine. The difference from the other sections is the emphasis placed upon teaching. The organization of appropriate knowledge and the method of transmitting it most efficiently to the practicing profession, as well as, the house staff, is the primary responsibility.

The definition of the responsibility of the Director of Medical Education as a new position in the hospital needs to be clarified. Many staff members consider it to be for recruiting and scheduling of house staff. Others attempt to place the entire educational program on the shoulders of the Director of Medical Education. The necessity of staff involvement on an active, cooperative basis for the success of these programs needs to be emphasized. The Director of Medical Education is not a super resident at the beck and call of the attending staff, but a fellow professional man with whom a two-way exchange of effort for the common good is due. The technical details are unknown due to a neglect of serious studies of these problems. The Ohio State Medical Association is to be complimented for its recognition of the need and its willingness to pioneer in this exciting field of medicine.

Obituaries

Ad Astra

Emerson Victor Arnold, M. D., Delaware; Ohio State University College of Medicine, 1928; aged 69; died May 23; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for some 35 years in Delaware, Dr. Arnold also was on the staffs of two Columbus hospitals. A veteran of World War I, he was a member of the American Legion. Other affiliations included memberships in the Rotary Club, Elks Lodge, Masonic Lodge and the Episcopal Church. Among survivors are his widow, a son and a daughter.

Bernard L. Brofman, M. D., Cleveland; Western Reserve University School of Medicine, 1944; aged 47; died May 29; member of the Ohio State Medical Association, the American Medical Association, American College of Cardiology, and the American College of Chest Physicians; diplomate of the American Board of Internal Medicine. Long associated with a well-known cardiovascular research team in Cleveland, Dr. Brofman was former director of cardiovascular research at Mount Sinai Hospital. Recently, he was engaged in private practice and part-time research. A high point in his career was a trip to Israel as member of a team demonstrating new techniques in treatment of heart disease. A former Army Medical Corps officer, he was a member of the Temple and the Masonic Lodge. Survivors include his widow, two sons, a daughter, his parents, and a sister.

John Redman Claypool, M. D., Mount Vernon; University of Michigan Medical School, 1909; aged 79; died May 9; member of the Ohio State Medical Association and the American Medical Association; past president of the Knox County Medical Society. A native of Mount Vernon, Dr. Claypool began his practice at nearby Gambrier and moved to Mount Vernon two years later. His professional career in the area extended over about 45 years before his retirement. He was a veteran of World War I and a member of the American Legion; also a member of the Masonic Lodge and the Episcopal Church. Among survivors are his widow, a son and a daughter.

Robert P. Hagerman, M. D., Waverly; University of Maryland Medical School, 1923; aged 69; died May 5; member of the American Psychiatric Association. Dr. Hagerman was for about three years medical director at the Chillicothe Federal Reformatory, and formerly associated with the medical services of other federal penal institutions as well as the U. S. Public Health Service. His widow survives.

Morris Hyman, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1927; aged 63; died May 19; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Otolaryngology. A native of Cincinnati, Dr. Hyman began practice there after postgraduate studies abroad, specializing in otolaryngology. A member of the Temple, he was a leader in numerous groups such as the Zionist Organization, Jewish Community Relations Committee, B'nai B'rith, Bonds for Israel, and the Jewish National Funds Campaigns. Among survivors are his widow, three daughters, two brothers and two sisters.

Harris Durkee Iler, M. D., Cleveland; Western Reserve University School of Medicine, 1927; aged 68; died May 18; member of the Ohio State Medical Association and the American Medical Association. Before his retirement, Dr. Iler practiced for about 20 years in the Lakewood area.

Joseph Thomas Nakayama, M. D., Cincinnati; University of Cincinnati College of Medicine, 1924; aged 70; died March 7; former member of the Ohio State Medical Association; member of the American Academy of General Practice. Dr. Nakayama practiced for many years in the Cincinnati area.

George Augustus Pierret, M. D., Cincinnati; University of Cincinnati College of Medicine, 1901; aged 89; died January 31; former member of the Ohio State Medical Association. Dr. Pierret had not been in practice for many years.

Ursus Victor Portmann, M. D., Tucson, Arizona; Western Reserve University School of Medicine, 1913; aged 79; died May 21; former member of the Ohio State Medical Association; member of the Roentgen Ray Society and the Radiological Society of North America; diplomate of the American Board of Radiology. Dr. Portmann was director of therapeutic radiology at the Cleveland Clinic for 30 years before he moved to Arizona about 1952. He is survived by his widow, a son, and two brothers.

Harry Prushing, M. D., Columbus; Ohio Medical University, Columbus, 1902; aged 90; died May 27; former member of the Ohio State Medical Association. A practicing physician for many years in Columbus, Dr. Prushing retired in 1956. Survivors include a son, a daughter, two brothers and a sister.

J. Edwin Purdy, M. D., Canton; University of Pennsylvania School of Medicine, 1918; aged 74; died May 16; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. A

practicing physician and surgeon in Canton for many years, Dr. Purdy was a past president of the Stark County Medical Society. He was a member of the Masonic Lodge, the Presbyterian Church, and was a veteran of World War I. Survivors include his widow, a daughter, and two sisters.

Harry Clifford Rosenberger, M. D., Cleveland; Western Reserve University School of Medicine, 1919; aged 74; died May 16; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Otolaryngology, American Otological Society; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology. A physician and surgeon in Cleveland for many years, Dr. Rosenberger retired about a year ago. He was a member of the Masonic Lodge, the American Triological Society and the Pasteur Club. Survivors incude his widow, two daughters, a stepdaughter, and two sons.

George Wallace Ryall, M. D., Cleveland; University of Cincinnati College of Medicine, 1919; aged 72; died May 7; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Otolaryngology, and the American Society of Ophthalmologic and Otolaryngologic Allergy. An eye, ear, nose, and throat allergy specialist, Dr. Ryall practiced for years in Cleveland. He moved there after several years of practice in Wooster, his native city. Survivors include his widow, three sons, and a sister.

Samuel Bernard Sonkin, M. D., West Union; Eclectic Medical College, Cincinnati, 1938; aged 55; died May 12; member of the Ohio State Medical Association and the American Medical Association. A resident of Columbus during his early life, Dr. Sonkin received his early education there before going to medical school. His practice in the West Union area extended over about 25 years. Survivors include his widow, three daughters, two brothers, and three sisters.

Alexander Wylie, M. D., Ripley; Medical College of Ohio, Cincinnati, 1895; aged 92; died May 8. A native of Ripley, Dr. Wylie was the son of a physician, and served all of his professional career in the Brown County area. He was a member of the Methodist Church and was active in public education work in the community. A daughter and two sons survive.

Edward Zimmer, M. D., Trotwood; Medical Faculty of the University of Vienna, 1925; aged 65; died May 15; member of the American Medical Association. Dr. Zimmer was chief of the geriatrics service at the Veterans Administration center in Dayton. He moved to Dayton after practicing in Jamestown, N. Y. A member of the Temple, he is survived by his widow.

Heart Group Offers Handbook On Low-Sodium Diets

The Franklin County Heart Association, 3416 N. High Street, Columbus, has announced the forthcoming *Low-Sodium Handbook,* sponsored in cooperation with the Columbus Dietetic Association. Geared to the locale of the sponsoring groups, the illustrated booklet is of general nature.

It is a handbook to be used in conjunction with a prescribed low-sodium diet and is intended to help the patient follow the restricted diet prescribed by his physician. It explains sodium in relation to food needs and offers suggestions for buying and preparing low-sodium meals. Available from the above organization in mid-summer at 50 cents per copy.

Dr. William S. Jasper, Sr., Lancaster, was elected president of the Central Ohio Urological Society at the group's meeting in Columbus.



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Due to the overwhelming response to our first Hawaiian Carnival trip, your committee has selected another date to accommodate all our members wishing to take advantage of this fabulous dollar saving vacation.

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Nowhere else, to our knowledge, can you find a 13-day luxury Hawaiian Holiday for just $599.00, including round-trip jet, first-class hotel accommodations, meals and beverages. The dates we have selected for this fabulous autumn vacation are Sunday, November 27 departure with return to Cleveland on Sunday, December 11. Read the information carefully and I believe you will agree that here is the opportunity of a lifetime and a vacation of a lifetime for you, your family and your fellow members.

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Ohio Academy of General Practice...

16th Annual Scientific Assembly Scheduled in Columbus, Tuesday-Thursday, August 2-4; Program Events Announced

THE Ohio Academy of General Practice has announced its 16th Annual Scientific Assembly to be held at the Sheraton-Columbus Hotel in downtown Columbus, on Tuesday, Wednesday, and Thursday, August 2, 3, and 4.

Registration begins at noon on Tuesday, August 2, and the program continues to noon on Thursday. Following are program highlights.

Tuesday, August 2

Registration opens at 12:00 noon.
Introductions

What Is a Neonatalogist? — Doris A. Howell, M. D., Philadelphia.

Malignancy in Childhood — Robert D. Mercer, M. D., Cleveland.

The GP as the Prime Iatrogenologist — Walter W. Sackett, M. D., Miami, Fla.

Common Sense Management of Acne Vulgaris — William E. Pace, M. D., London, Ontario.

Wednesday, August 3

Breakfast Session (7:30 - 8:45 a. m.)

1. **Current Trend in Erythroblastosis Fetalis** — Dr. Howell.
2. **Culprit in Diabetes—Fat or Sugar?** — Dr. Sackett.
3. **Chromosomes of Man** — Dr. Mercer.
4. **Mechanism and Action of the Anti-Infective Drugs** — John C. Krantz, Jr., M. D., Baltimore.
5. **How to Differentiate Injury-Prone Individuals** — James A. Nicholas, M. D., New York City.

Modern Drug Incompatability — Dr. Krantz.

Common Athletic Injuries; Pitfalls in Diagnosis and Treatment — Dr. Nicholas.

Diagnosis and Differential Diagnosis and Treatment of Migraine — Arnold P. Friedman, M. D., Bronx, N. Y.

Diagnosis and Treatment of Common Pulmonary Diseases — Murray Sachs, M. D., Pittsburgh, Pa.

Luncheon Sesison (12:30 - 1:45 p.m.)

1. **Sex Education** — M. Edward Davis, M. D.
2. **Diagnosis and Treatment of Atypical Pneumonia** — Dr. Sachs.
3. **Metabolic Bone Disease: Difficulties of Definition and Diagnosis** — E. D. Pellegrino, M. D., Lexington, Ky.
4. **Local Ear Medication** — Ralph J. Caparosa, M. D., Pittsburgh.
5. **Heart Disease, Cancer and Stroke Regional Programs** — Michael DeBakey, M. D., Houston, Texas.

Wednesday Afternoon

Office Otology-Dizziness — Dr. Caparosa.

Surgery of Arteriosclerosis — Dr. DeBakey.

A New Look at Inguinal Anomalies — H. William Clatworthy, M. D., Columbus.

Hyperparathyroidism: Diagnostic Difficulties — Dr. Pellegrino.

Evening: Marion Laboratories Party and Officers Reception.

Thursday, August 4

Management of Essential Hypertension and Hypertensive Emergencies —Ray W. Gifford, M. D., Cleveland.

Gynecologic Problems in Adolescence — Robert W. Kistner, M. D., Brookline, Mass.

Dysfunctional Uterine Bleeding — Robert B. Greenblatt, M. D., Augusta, Ga.

Estrogen and the Retardation of Aging in Women — M. Edward Davis, M. D., Chicago.

Adjournment at 12:15 p. m.

AMA Medical and Health Films Being Shown at Record Rate

A total of 11,635 medical and health films were lent to physicians, hospitals, medical schools or other professional groups by the American Medical Association Film Library during 1965.

Most of the films were employed as educational material for physicians, medical students and nurses.

The library now consists of 2,130 copies of 458 films. The total includes 119 health films which can be used by physicians who are invited to address lay groups. A current list of these films is now available.

Activities of County Societies ...

CLINTON

Dr. Foster J. Boyd spoke on the subject of the American Cancer Society at the meeting of the Clinton County Medical Society on May 24 in the Clinton Memorial Hospital dining room.

To indicate the importance of this organization, he gave some statistics on volume of cancer patients seen at the local hospital since its opening in 1951. He also contrasted the voluntary health organization way of doing things as opposed to the "let Uncle Sam do it" philosophy.

CUYAHOGA

Dr. David Fishman took office as president of the Academy of Medicine of Cleveland at its annual meeting at the Mid-Day Club on May 13. He succeeds Dr. William F. Boukalik.

Dr. Elden C. Weckesser was named president-elect in the mail vote, to take office as president in 1967. Dr. John J. Grady was named vice-president; and Dr. Fred R. Kelly was re-elected secretary-treasurer.

Distinguished memberships in the Academy were awarded to Dr. Harry Goldblatt, director of research at Mount Sinai Hospital; Dr. Alan R. Moritz, provost of Western Reserve University; and Dr. Irvine H. Page, who recently retired as director of research at the Cleveland Clinic.

Dr. John H. Budd was given a citation for his contributions to medicine through his services to the Academy, the Ohio State Medical Association, and the American Medical Association.

FRANKLIN

Members and guests of the Academy of Medicine of Columbus and Franklin County had a choice of two programs at the May meeting in the Neil House, downtown Columbus hotel.

Following a social hour and dinner, Dr. Frank Moya, anesthesiologist at the University of Miami (Florida) School of Medicine, spoke in one session on "Transmission of Drugs Across the Placenta."

In the other session, Dr. Vol K. Philips moderated a panel on Medicare. Included among panel speakers were Dr. Russell B. Roth, chairman of the AMA Medical Service Committee; Fred B. Wolf, regional representative of the Social Security Administration; Hugh F. Hughes, Medicare manager in Ohio for the Nationwide Insurance Company; and Frederick J. Zuber, chief of the Ohio Division of Health and Rehabilitation Services.

HAMILTON

Results of the annual elections of the Academy of Medicine of Cincinnati were announced at the May meeting. At the September 20 annual meeting, Dr. Elmer R. Maurer, who was named president-elect a year ago, will succeed Dr. Robert M. Woolford as president.

Dr. Stanley D. Simon was named president-elect, and will take office as president in September, 1967. Other officers elected are Dr. John J. Will, secretary; Dr. Robert S. Heidt, treasurer; Dr. William R. Culbertson, trustee for a three-year term; and Dr. Warner A. Peck, councilman-at-large for a three-year term.

The Academy of Medicine of Cincinnati with the Auxiliary held the "President's Dinner" meeting on May 17 in the Daniel Drake Auditorium at the headquarters building. A social hour and dinner were part of the evening's events.

JEFFERSON

In March, 1966, the Jefferson County Medical Society began its program of regular monthly meetings at the Steubenville Country Club under the direction of the following officers: Jack R. Cohen, M. D., president; Lee A. Rosenblum, M. D., president-elect; Irving Dreyer, M. D., secretary-treasurer; Sanford Press, M. D., delegate; Crist G. Strovilas, M. D., alternate delegate; Aniceto Carneiro, M. D., censor; John P. Smarrella, M. D., censor; Warren G. Snyder, M. D., censor.

The Society actively participates in such community health activities as the Jefferson County Association of Health and Welfare Agencies, the Jefferson County Mental Health Association, the Jefferson County Head Start Program, the Steubenville Care of the Aged Program, and confers with representatives of local industry on health insurance programs.

Society officers participated in the Annual Conference of County Medical Society Officers in February and at the Annual Meeting of the Ohio State Medical Association at Cleveland in May.

Dr. Sanford Press of this Society was elected Councilor for the Seventh District, O. S. M. A.

Guest speakers at dinner-meetings have been: Stephen H. Hart, M. P. H., Steubenville Health Commissioner; "Health Planning for the Aged in Steubenville, and, the Head Start Program in Jefferson County"; J. Philip Ambuel, M. D., Professor of Pediatrics, O. S. U. College of Medicine and director of out-patient department of The Children's

Hospital, Columbus: "The Birth Defects Program." —Irving Dreyer, M. D., Chairman, Committee on PR.

LUCAS

The Inter-Hospital Postgraduate Lecture Series was presented on May 12 and 13 with Dr. Robert D. Johnson, associate professor at the University of Michigan, as guest speaker. Theme for the series was, "Some Recent Advances in Medicine."

During the Specialty Section meeting on May 19, the subject, "Iron Metabolism and Anemia in Pregnancy," was discussed by Dr. Curtis Lund, professor of obstetrics and gynecology, University of Rochester. The program was jointly sponsored by the Toledo OB-GYN Society.

The Academy of Medicine of Toledo and Lucas County has scheduled its annual Academy Golf Tournament on Thursday, July 14, at the Sunningdale Gold Course, 2162 W. Alexis Road. Tee off time is 11:30 a. m. to 2:00 p. m. A refreshment period will be followed by a steak dinner at 6:30 p. m.

MAHONING

The Mahoning County Medical Society held two meetings for the purpose of enlightening members on the coming Medicare regulations. The first meeting, held on April 19, consisted of a panel to discuss Medicare rules. Panel members were: Dr. Jack Schreiber, Dr. Robert E. Tschantz, and Dr. Carroll L. Witten. Dr. Witten is a member of the 16-man Health Insurance Benefits Advisory Commission, appointed by President Johnson. Dr. Harold J. Reese, president-elect, presided at the meeting.

The second meeting, held on May 17, was for the purpose of general discussion and questions and answers. Dr. Jack Schreiber, program chairman, answered questions on Medicare. At that meeting, the Mahoning County Medical Society endorsed a resolution approving an Individual Responsibility Plan. Dr. F. A. Resch, president, presided.

OTTAWA

Members of the Ottawa County Medical Society and the Auxiliary attended a dinner meeting on May 12 at the Catawba Cliffs Beach Club.

SENECA

Members of the Seneca County Medical Society were hosts to members of the Seneca County Bar Association at a ladies' night dinner meeting on May 10 in Tiffin. Guest speaker was Bernard O'Kelly, Ph. D., professor of English at Ohio State University, whose topic was "Language — A Key to Identity."

SUMMIT

The Summit County Medical Society held its monthly meeting on May 3 in the Children's Hospital auditorium. Speaker was Dr. J. L. Ankeney, professor of surgery at Western Reserve University School of Medicine, whose topic was "Current Status of Surgery in Cardiovascular Disease."

Dinner preceded the meeting at the Akron City Club.

Director Is Named at Ohio State For Allied Medical Services

Dr. Robert J. Atwell, former chief of medical service at the Ohio Tuberculosis Hospital, has been named director of the new School of Allied Medical Services in the Ohio State University College of Medicine.

In his new position, Dr. Atwell will direct the educational programs for paramedical services at Ohio State. Under his jurisdiction will be the medical dietetic program, physical therapy, occupational therapy, x-ray technology, medical technology, medical illustration, nurse anesthesiology, and orthoptics.

Ohio State's Board of Trustees in April approved establishment of the School of Allied Medical Services effective July 1.



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References on request

Auxiliary Annual Meeting Report ...

Auxiliary Convenes in Cleveland in Conjunction with OSMA Annual Meeting; Sessions in Sheraton-Cleveland

By MRS. S. L. MELTZER, Portsmouth
Chairman, Publicity Committee

"MANY hands make light work." One John Heywood (who had much to say about many things) wrote that back in the 16th century and to a point he was right. I would dare to paraphrase that quotation by saying "many hands make inspired and more effective work" and, of course, I have in mind the 150 Cuyahoga County women who served on the year's convention committee under the forceful leadership of Mrs. Burdett Wylie, chairman, and Mrs. Roscoe J. Kennedy, cochairman. According to no less an authority than Mrs. Herbert F. Van Epps, 1965-66 President of the Woman's Auxiliary to the Ohio State Medical Association, "everybody worked hard, but the wonderful thing is that each committee member gave strong evidence of enjoying herself and having a ball."

This twenty-sixth annual meeting at the Sheraton-Cleveland, Tuesday, May 24 through Friday, May 27, was informative, interesting and full of accomplishment. It highlighted that cherished "first" — the invitation from OSMA to attend each of its three General Sessions. And believe me, the Auxiliary DID turn out! Thank you, gentlemen, for this very great privilege.

Approximately 300 doctors' wives registered for this 1966 meeting presided over by Mrs. Van Epps, Tuscarawas County. Mrs. Karl F. Ritter, Allen County, served as parliamentarian. The first session on Wednesday morning, May 25, began with the invocation by the Rev. Allen Blackman of First Methodist Church, Dover. This was followed by the House of Delegates' pledge of allegiance and pledge of loyalty as led by Mrs. A. L. Kefauver, first vice-president, Franklin County. A cordial note of welcome was sounded by Mrs. Elden C. Weckesser, president, Cuyahoga County, to which Mrs. James Zeller, president, Tuscarawas County, was privileged to give the response. Mrs. J. Kenneth Potter, Cuyahoga County, introduced these out-of-state guests: Mrs. Lucian Fronduti, president, and Mrs. Manuel Bergnes, president-elect, Pennsylvania Auxiliary; Mrs. Wilson Smith, president, Mrs. Hu Myers, president-elect and Mrs. Bruce Martin, state AMA-ERF chairman, West Virginia Auxiliary; Mrs. Raymond Jones, president-elect, Kentucky Auxiliary. Mrs. Van Epps then introduced her convention chairman and co-chairman. Mrs. Wylie expressed deep gratitude to her committee members and made special mention of the fine work done by Mrs. Kennedy and Mrs. Vincent T. Kaval on the printed program. Also introduced to the House of Delegates were Mrs. Henry Crawford, wife of the President of OSMA, and Mrs. William H. Evans, immediate Past National President.

Several pertinent announcements and adoption of the Rules of Convention preceded the report on Roll Call. It was moved that the minutes of the 1965 convention not be read since they had already been published in the *Auxiliary News*. Motion approved. Mrs. R. L. Wiessinger, Allen County, presented her treasurer's report. The motion to accept that report as audited was duly approved. First reading of the report of the Resolutions Committee was presented by Mrs. John Toepfer, Hamilton County. Three such resolutions were submitted.

Nominations

On the agenda under new business came the report of the Nominating Committee by its chairman, Mrs. John D. Dickie, Lucas County. Following this reading, the President asked for nominations from the floor for each office on the first nominative slate for officers, district directors and directors-at-large. Since there were no nominations from the floor, Mrs. Van Epps declared the nominative slate the elected slate. (See page 749 for names of new officers.) The President then asked for nominations from the floor for members of the 1966-67 Nominating Committee: From the Board, four to be nominated, two elected; from the membership, ten to be nominated, five elected. There being no nominations from the floor, it was moved that nominations as presented by the Nominating Committee be closed, subject to election Thursday afternoon between 3:00 and 5:30 p. m. in the Mezzanine Lobby East. Motion carried.

Thirty-six names were placed in nomination from the floor for delegates and alternates to the National Auxiliary convention to be held in Chicago from June 26 through June 30. These names were also

to be voted on Thursday afternoon. It was moved that the chairman of delegates be empowered to move any alternate to delegate if necessary and that the President be empowered to appoint any member in good standing who is present in Chicago as an alternate, should that be necessary. Motion approved.

Mrs. George T. Harding III, Franklin County, chairman of the Reference and Revisions Committee, presented the two proposed changes in the bylaws which had already been approved by the State Board and by the Advisory Committee of OSMA, and which had been printed in the *Auxiliary News* and sent by letter to all county presidents for consideration and instruction of delegates. The first proposed amendment had to do with Section 5-C-2, under duties of President-Elect, and recommended the deletion of "membership chairman" under those duties. Motion was made that this amendment be accepted. Motion carried.

The second proposed amendment had to do with Article VII, Section 7, on Resolutions: As it originally read — "all resolutions from component auxiliaries . . . shall be referred to the Committee on Resolutions no later than *30 days* before the annual meeting . . ." The amendment would change the "30 days" to "90 days" and insert after the first sentence these additional words: "Not less than 60 days before the annual meeting all resolutions approved by the Advisory Committee and the Resolutions Committee shall be sent to each component auxiliary." It was moved that this second amendment be accepted. Motion carried.

Board Recommendations

Mrs. James N. Wychgel, Cuyahoga County, State President-Elect, moved the acceptance of this recommendation as it was presented in a letter to the county presidents: "We asked for and received permission from our State Advisors to allow two or more of our unorganized counties with very few members to unite and form one organization as is done in other states. This is to apply largely to unorganized counties and must have the approval of the Medical Societies of these counties as well as approval of the State Board." There was considerable discussion on this recommendation, revolving largely around the limitation imposed by the term "unorganized" and the fact that that word had been omitted from the statement appearing in *Auxiliary News*. The parliamentarian was asked for clarification of the motion. The vote then taken on the original recommendation was defeated.

Mrs. Wychgel then presented a new motion for acceptance of the same statement but with the omission of the word "unorganized" in the phrase "allow two or more unorganized counties to unite." Motion passed. However, further discussion revealed that this is a recommendation only and that necessary steps will have to be taken to amend the bylaws.

Mrs. Calvin Warner, Hamilton County, Finance Committee chairman, moved the adoption of a recommendation to raise the State dues from $1.25 to $3.00 annually. Considerable discussion also followed this recommendation. A deferral amendment was defeated and the original motion for adoption of the dues increase was then voted upon and carried.

The first business session of this twenty-sixth meeting was adjourned at 11:30 a. m. to permit Auxiliary delegates to attend the OMPAC luncheon at noon. Dr. Hoyt D. Gardner of Louisville, Kentucky, a member of AMPAC's Board of Directors, was the luncheon's dynamic speaker who, later, was described by many as a "spellbinder." His stirring words on "Success Can Be Ours" brought him a standing ovation. The first of OSMA's three General Sessions was held at 1:30 p. m. and featured "Problems in Marriage" with a star-studded panel.

It was at 3:00 p. m. that Auxiliary members reconvened in the Cleveland Room to hear the two-minute reports of Ohio's county presidents. It amazes this reporter how much vital, helpful data can be encompassed into a two-minute presentation. There was a wealth of Auxiliary activity paraded in those reports. They spelled out clearly the dedication to the medical profession that underlies every Auxiliary project. The "extracurricular" part of Wednesday's program was the between 5:30 and 7:30 p. m. escorted trips to Hixon's Barn — a fascinating and relaxing jaunt (also available on Thursday). Nor will anyone who was there be likely to forget the mammoth, tempting ice cream cone which looked like a prop out of Disneyland.

Thursday Session

The second business session convened in the Cleveland Room on May 26 at 9:15 a. m. Mrs. Van Epps welcomed the delegates, alternates, and guests and introduced Mrs. Richard A. Sutter, National Auxiliary President. Dr. Henry A. Crawford, President of OSMA, was on hand to greet the Auxiliary members and to express his gratitude for the outstanding job the Auxiliary is doing. He cautioned that the medical profession heed these words: "Stop fighting among yourselves, but fight the politicians."

Additional out-of-state guests were introduced: Mrs. Frank Gastineau, Past President, National Auxiliary; Mrs. John Deever, president-elect, Indiana; Mrs. W. G. Gamble, first vice-president, and Mrs. Earl Weston, second vice-president, Michigan. The motion was made that the reading of the previous day's minutes be dispensed with (they will appear in the *Auxiliary News*). Motion carried.

Mrs. John Toepfer, chairman of the Resolutions Committee, gave the Second Reading of the three proposed resolutions. The first resolution regarding Mental Health facilities called for reorganization of these facilities. This resolution is similar to one

passed by OSMA. Mrs. Toepfer moved the adoption of this resolution. Motion carried.

Following careful study, the Resolutions Committee and Dr. Benjamin C. Diefenbach, chairman of advisors, recommended that Resolution No. 2 not be adopted (it had to do with traffic safety and included recommendations for periodic driver physical examinations and an increase in the minimum driver age to 18). Mrs. Harry Fry, legislation chairman, stated that the preamble of this resolution is politically controversial. There was considerable discussion (raising the minimum age of drivers had been defeated in the State Legislature). The carrying out of periodic physical examinations was, according to those carefully studying the question, completely unrealistic and impractical since it would involve an increase of some 300 patients a month per doctor. Mrs. Toepfer moved the resolution not be adopted. Motion carried.

The third resolution recommended that the name of Mrs. C. A. Colombi, Cuyahoga County, past state president and past National community service chairman, be submitted to the 1966-67 National Nominating Committee for National office. Mrs. Toepfer moved adoption of this resolution. Motion carried. Mrs. Toepfer read a courtesy resolution expressing gratitude to the many individuals and groups who contributed to the success of the convention. Mrs. Calvin Warner, Hamilton County, Finance Committee chairman, stated that copies of the budget for 1966-67, as approved by the Board, had been distributed to the House of Delegates. She moved the adoption of the budget. Motion carried.

President's Report

It was with obvious pride that Mrs. Van Epps highlighted the accomplishments of Ohio's Auxiliaries and their 5,599 members (to date). There are 67 members-at-large — more than for some time. She remarked on the variety of community service projects and reviewed the activities of the various committees. She spoke of her "fringe benefits" as President — the cooperation and fellowship she enjoyed and the privilege of visiting the many counties over the state. Her parting words were particularly meaningful: "It's not what you have, but what you do with what you have that matters." Mary Louise Van Epps was accorded an enthusiastic standing ovation.

Next introduced to the House of Delegates was Dr. Lawrence C. Meredith, of Elyria, Incoming President of OSMA. Dr. Meredith spoke forcefully on the need for creative thinking in working out present-day problems. He stressed the importance of working before election to change the complexion of Congress. "See to it that the dove that flies into the kitchen," he counseled, "turns into a screaming eagle of tremendous activity." He also pointed out that an AMPAC button and a winning smile could be an unbeatable combination.

Mrs. Van Epps then recognized Mrs. R. L. Wiessinger, Allen County, who read a resolution from the Board recommending the name of Mrs. Karl F. Ritter for Honorary Membership in the Ohio State Auxiliary. Mrs. Ritter, named on this year's National nominative slate for the office of President-Elect, is a past state president, a present National director and chairman of Organizational Reports. She has, in addition, served three years as National AMA-ERF chairman, four years as National finance secretary and one year as National treasurer — an impressive record. Mrs. Calvin Warner read the honorary membership certificate recommended for Mrs. Ritter and moved that such honorary membership in the state organization be accorded Mrs. Ritter. Motion was carried by unanimous vote.

Credits and Awards

This was the "big" moment — that moment when county auxiliaries are honored for their year's endeavors. Mrs. C. L. Johnson, Hardin County, Credits and Award chairman, made the presentations. There are seven membership categories and three

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types of awards — the Certificate, the Certificate with Gold Seal, and the top honor, the Certificate with Gold Seal and Blue Ribbon. Here's how those awards shaped up: In the 1-17 category: Lawrence, Morrow and Union, the Certificate; Clermont, Certificate with Seal and Ribbon. 18-30: Logan, Certificate; Coshocton, Delaware, Geauga, Greene, Hardin, Medina, Ottawa, Van Wert and Washington, Certificate with Seal; Huron, Seal and Ribbon. 31-50: Fairfield, Hancock, Jefferson and Sandusky, Certificate; Belmont and Knox, with Seal; Tuscarawas, with Seal and Ribbon. 51-75: Marion, Certificate; Columbiana, Lake, Licking, Muskingum and Scioto, with Seal; Erie, with Seal and Ribbon. 76-150: Butler, Clark and Lorain, Certificate; Richmond and Trumbull, with Seal; Allen, with Seal and Ribbon. 151-300: Stark and Mahoning, Certificate with Seal. 301 and up: Lucas and Summit, with Seal; Cuyahoga, Hamilton and Montgomery, with Seal and Ribbon.

Another high spot of the morning was the presentation of awards for AMA-ERF by Mrs. R. K. Ramsayer, Stark County, chairman. She announced first that total contributions to date were $37,702.52. The largest contribution — $5,325 — came from Summit County. The greatest per capita contribution — $55.20 per member — came from Tuscarawas County. Honors for the greatest increase over last year went to Hamilton County.

This year there was no Memorial Service in the traditional sense. In accordance with a Board decision, the name and record of Auxiliary service of deceased members will be published in the *Auxiliary News*. Names of deceased members of this past year were included in the Convention program. Further, the Board voted an In Memoriam gift to AMA-ERF of $100. Mrs. Van Epps called for a moment of silence Thursday morning to honor the memory of those who had died. The second business session was adjourned at 11:00 a. m.

Tuscarawas County (Mary Louise's "home base") served as hostess for a social hour at 11:30 a. m. in the Whitehall Room. Luncheon followed at noon, honoring past state president, county presidents, presidents-elect, out-of-state guests and presidents of WA - SAMA. Special honored guests included Mrs. Richard A. Sutter, National President; Mrs. William H. Evans, immediate Past National President and Ohio's state officers. Luncheon arrangements were handled by the Lake County group. Mrs. John Dickie, past state president, gave the invocation. An exquisite gold pendant watch was presented to Mrs. Van Epps by Dr. Robert Kuba on behalf of the Tuscarawas County Medical Society, as a gesture of appreciation and gratitude for the part so well played by Mary Louise as State President.

Again, at 1:30 p. m., Auxiliary delegates and guests attended another General Session — this one a vitally informative talk by Ohio's prominent Dr. Charles L. Hudson, President-Elect, AMA on "Medicare's Rules and Regulations and Their Effect on the Practice of Medicine." Dr. Hudson received a standing ovation.

And at 3:00 p. m., Mrs. James Wychgel, President-Elect, presided at the Auxiliary's School of Instruction for 1966-67. Especially emphasized were Legislation and AMA-ERF. Some of the state chairmen outlined the year's program in the different categories. Mrs. Wychgel announced that she, her officers and her committee chairmen stand ready at all times to help local groups.

Doctors' Breakfast

That's how Friday, May 27, began — with a "Doctors' Breakfast" — at 7:30 a. m.! The early hour seemed to deter no one. Certainly "a goodly crowd was there" (to quote somebody . . .). Mrs. Joseph F. Corsaro, chairman, and her two cochairmen, Mrs. Leonard A. Backiel and Mrs. Thomas L. Manning, wore the traditional chefs' hats (and most becomingly). Special guests were Dr. Charles L. Hudson, Dr. Henry A. Crawford, Dr. Lawrence C. Meredith and Mrs. Richard Sutter. Mrs. M. W. Sloan II, 2nd vice-president, gave the invocation.

Mrs. Van Epps started the ball rolling with the introduction of Ruth Wychgel, President-Elect. The "piece de resistance" of the Breakfast Hour was Higbee's Fashion Show for Men. The models, be-

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lieve it or not, were eight courageous, wonderful Cuyahoga County doctors as well as a doctor's teenage son. They did a beautiful job of preening, posing, walking, exhibiting — the latest in men's fashions. There were colors and fabrics to slenderize the figure (for calorie-conscious M. D.'s); white trousers and sports jackets have sneaked in out of the past; men do wear hats and topcoats and carry umbrellas and wear ties (Higbee's should know!). There was the casual look, the golfer look, the evening look — the look for yachting, tennis, and what have you.

Dark slacks and stripes of all kinds are "in," and there was a maroon shirt with ascot no less. And how handsome the men looked in the tuxedo with shawl collar and the after-five Teal blue dinner jacket and the "softer" shirts for evening wear! All in all, it was quite a show. The models did themselves — and their wives — proud. A boutonniere — at least — to these good sports: Dr. James Coviello, Dr. Eugene Gessler, Dr. Edward Kieger, Dr. Ralph Kovach, Dr. Jerome Litt, Dr. Chester Lulenski, Dr. J. Kenneth Potter, Dr. Paul Sindelar and Larry Kennedy, son of Dr. and Mrs. Roscoe Kennedy.

The third business session convened at 9:45 a. m., May 27 in the Cleveland Room. Mrs. Burdett Wylie, convention chairman, presented the AMA-ERF chairman with a $125 contribution from the Convention Committee. This contribution was made possible through the extra efforts of the committee in making paper money corsages, centerpieces and French beading favors. Mrs. Karl F. Ritter introduced the National Auxiliary President, Mrs. Richard A. Sutter. In a stimulating talk, Mrs. Sutter discussed three important areas: that of health education, of public health and of the role of community organizations. "There is inadequacy of health education," Mrs. Sutter told her audience, "and a great need for improving it . . . there is lack of health education in the schools . . . and what is being done to raise the level of uneducated adults to help themselves?" She stressed that public health should be nonpartisan and that public health officials must have the support of organizations and professional groups in creating public awareness of the many problems. She remarked that in community action there is a conflict between a liberal concern for humanity and a conservative concern for freedom. She emphasized that Auxiliary members must work together on local, state and national levels.

The report of the Election and Tellers Committee revealed these results of the previous day's voting for members of the 1966-67 Nominating Committee: Elected to that committee from the Board: Mrs. Herbert F. Van Epps and Mrs. A. L. Kefauver; from the membership: Mrs. John Toepfer, Mrs. E. P. Greenawalt, Mrs. Jack Weiland, Mrs. Joseph Moran, Jr., and Mrs. Paul Woodward, Jr. Also announced were the results of the previous day's voting on the 18 delegates and 18 alternates to the National Convention in June.

Installation

Mrs. Richard Sutter, National President, installed the new officers headed by Mrs. James N. Wychgel as president, and Mrs. Paul Sauvageot as president-elect. "This is more than merely a great honor conferred upon you," Mrs. Sutter said, "it is a real responsibility and challenge." And she went on to remind the Auxiliary membership that "these are *your* officers and you assume responsibility to them equal to theirs to you."

Mrs. C. A. Colombi, president of the Gavel Club (made up of past state presidents), presented the past president's pin to Mrs. Van Epps. "No one is ever honored for what she reecived, but rather for what she gave," Mrs. Colombi said, "and you have given much this past year." In telling Mrs. Van Epps that she was now eligible for membership in the Gavel Club, she played upon the letters in the word "gavel" to liken Mrs. Van Epps' endeavors in this fashion: Graciousness in a Presidential manner; Ability to administer wisely; Valiant in the upholding of our laws; Enthusiasm for all projects and plans; and Loyalty to all and to all things at all times.

Mrs. James Wychgel, newly installed president,

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said in her inaugural address "work together and you will be surprised at what comes out of it." She traced medicine's incredible historical background, comparing the past with the present. She spoke of the founding of the American Medical Association in 1847 when 250 physicians met in Philadelphia. She went on to emphasize the needs in many health related fields, especially in legislation and AMA-ERF. She announced a new state chairman—that of Health Education under Community Service. She suggested that Auxiliary members use as a guideline ten important two-letter words: "If it is to be, it is up to me." And she closed her remarks with this significant comment: "To work is to triumph — and triumph is just a little 'umph' added to 'try'." Mrs. Wychgel then asked for a rising vote of thanks for Mrs. Van Epps, the outgoing President. And at 11:45 a. m., Mrs. Van Epps declared the Twenty-Sixth Annual Convention of the House of Delegates adjourned.

"Happy Time," courtesy of the Cuyahoga Auxiliary, preceded the novel "Lunch-on-a-Cart" honoring the new officers, guests and members. Mrs. Edward L. Doerman, Lucas County, third vice-president, gave the invocation. The luncheon committee members were attired as perky French maids who helped create a distinctive atmosphere. To add to the gala occasion, Ruth Wychgel wore a beautiful crown of red carnations, presented by her county auxiliary. (She looked every inch the queen!) At 1:30 p. m., the Auxiliary attended OSMA's third General Session to hear another dynamic, enthusiastically received speaker, Dr. Edward R. Annis, Past President of the AMA, discuss "Care of the Patient: 1966."

One last orchid: To those many counties who made the Auxiliary's exhibit (in the OSMA Exhibit Hall) so completely outstanding, unusual and clever. It would be very easy to heap all sorts of superlatives on this "showing" without exaggerating in the least!

1966-67

This new Auxiliary year offers as many possibilities for outstanding activity as we have the interest, determination and capacity to "do." I said it last month, and I say it again: "Let's give it everything we've got."

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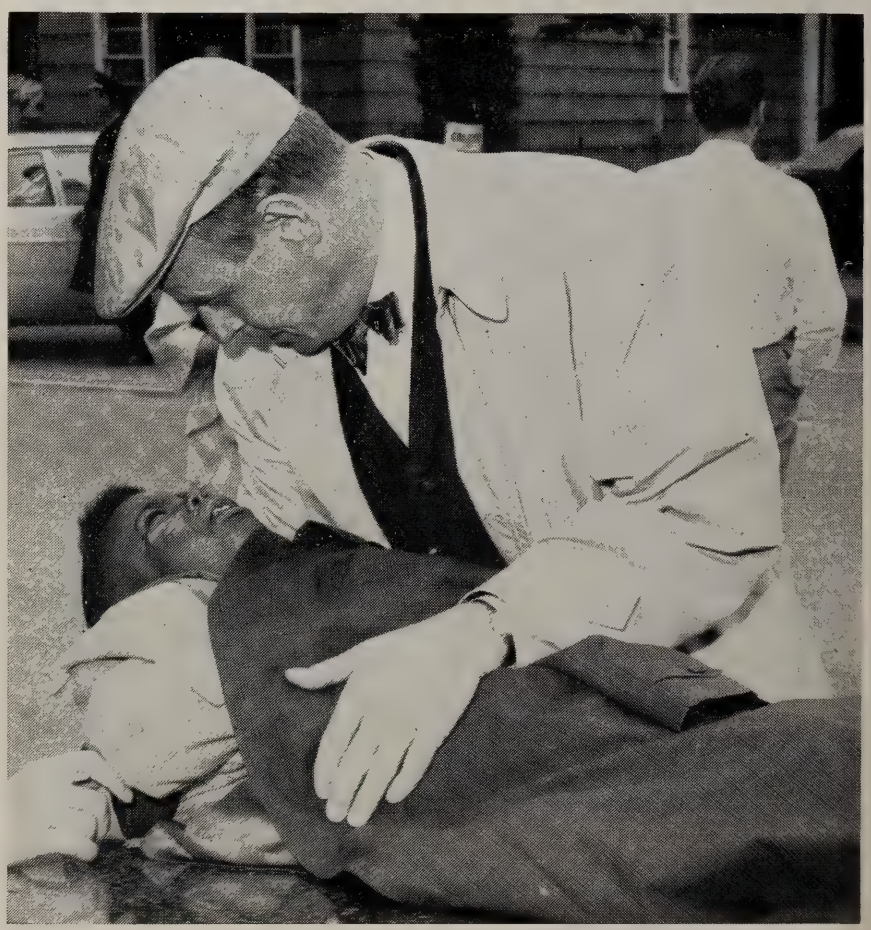


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Dr. Washam Named Executive Secretary Of the State Medical Board

Newly appointed executive secretary of the State Medical Board of Ohio is Dr. William T. Washam, former practicing physician at Jackson, and more recently engaged in the practice of law in Columbus. Dr. Washam has accepted the post on a part-time basis and will continue to devote some of his time to his medico-legal practice.

The announcement was made by Dr. Domenic A. Macedonia, of Steubenville, president of the Board, just before this issue of *The Journal* went to press. Dr. H. M. Platter, retired December 31, 1965, after 48 years as secretary of the Board.

Dr. Washam graduated from Ohio State University College of Medicine in 1945 and practiced in his native Jackson from 1946 to 1962. He received his law degree from Franklin University, Columbus, and was admitted to Ohio Bar on May 5, 1965. Dr. Washam is a member of the Ohio State Medical Association and the American Medical Association.

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"Finding the Hidden Diabetic" is the title of a new 39-minute sound film aimed at professional audiences and produced as an educational service of the Upjohn Company. Among four discussants presented in the film is Dr. Gerald T. Kent, Western Reserve University School of Medicine, who also acts as moderator of the panel. Requests for the film and also for brochures on the subject may be addressed to: Diabetes Detection Program, Room 914, 342 Madison Avenue, New York, N. Y. 10017.

The
OHIO STATE MEDICAL
Journal

VOL. 62 AUGUST, 1966 NO. 8

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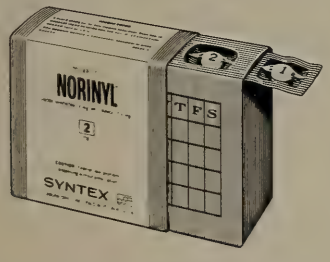
plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from

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LABORATORIES INC., PALO ALTO, CALIF.

Norinyl® tablets

(norethindrone 2 mg. ē mestranol 0.1 mg.)

for multiple contraceptive action

October 16-22 Is Designated as Community Health Week

The American Medical Association has officially designated a period in mid-October with the recommendation that County Medical Societies develop plans for Community Health Week.

F. J. L. Blasingame, Executive Vice-President of the AMA, addressed an open letter to County Medical Society officers and certain others in regard to this matter. The letter follows:

"The Board of Trustees has officially designated the week of October 16-22 as Community Health Week —1966 and established the corresponding week for the observance of Community Health Week in future years.

"We urge all state and county medical societies to develop appropriate programs marking this fourth annual observance of Community Health Week to encourage other members of the community health team to join with them in planning and carrying out activities.

"Community Health Week is a time for all local members of health professions and health organizations — public, private and voluntary — to conduct communitywide activities emphasizing the continuing theme of the observance — "Teaming Up for Better Health."

"Primary objectives of this nationwide observance are to stimulate greater public awareness and appreciation of the wealth of health facilities and services which are available at the community level and to stress the health progress and medical advances which have been made locally through the united efforts of all members of the community health team.

"We are again advising national health organizations and state and territorial health departments of our plans and encouraging them to participate actively in the promotion. We also are notifying them that their component local groups may be invited to participate wherever local observances are planned.

"To assist you in planning, we shall again prepare a kit of program suggestions and promotion materials. Promotional aids for 1966 will be concentrated on two appropriate local themes — the expanding career opportunities in medicine and its allied fields and overcoming preventable disease, with special emphasis on measles immunization and control of VD.

"If conflicting events make it impractical for your medical society to observe Community Health Week at the regularly scheduled time, we recommend that you schedule your local observance at another time close to the October 16-22 date so that you can derive maximum benefit from national publicity."

Dr. John W. Coles, Jr., practicing physician at Loudonville, has been named assistant dean for student affairs at Temple University School of Medicine, Philadelphia.

Bamadex® Sequels®

Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

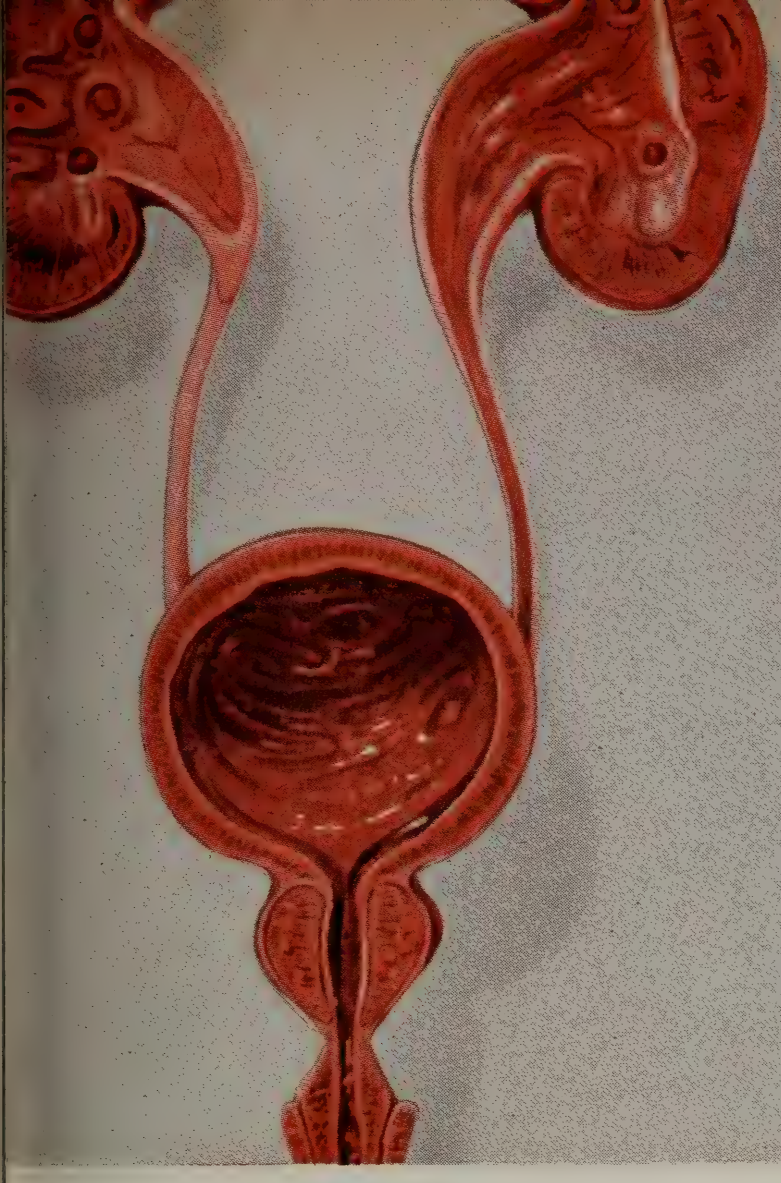
Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

NegGram®

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

Ohio Physician as Film Participant Discusses the "Flabby" Male

Dr. Herman K. Hellerstein, associate professor of medicine and director of the Fitness Evaluation Program, Western Reserve University School of Medicine, is one of the participants in a film, entitled "Reconditioning of Coronary Prone and Coronary Stricken Subjects."

Dr. Hellerstein and his colleague on the film panel, Dr. J. Willis Hurst, engage in an outspoken discussion on the "flabby" American male and the reasons why he is in "dreadful" condition.

Dr. Hellerstein quotes from impressive statistical evidence concerning the relationship of smoking to heart disease, and emphasizes the responsibility of the practicing physician to look for signs of the coronary prone individual during the patient's first office visit. It is a doctor-to-doctor discussion and is aimed at an audience of professional biomedical personnel.

This is one of a number of films produced under direction of the U. S. Public Health Service and available on a short-term loan basis from: Public Health Service Audiovisual Facility, Atlanta, Georgia 30333; Attn.: Distribution Unit.

A $40,000 Milbank faculty fellowship has been awarded to Western Reserve University School of Medicine in the name of Dr. Eugene Vayda, senior clinical instructor in preventive medicine.

Ohio State University Offers Courses for Physicians

The Center for Continuing Medical Education of the Ohio State University College of Medicine has announced a number of postgraduate courses of interest to physicians. Additional information may be obtained by writing William G. Pace, M. D., director of the center at 320 West Tenth Avenue in Columbus.

Courses announced at this time are the following:

September 12-14 — Medical Education Seminar

September 15-17 — Otolaryngology

September 19-21 — Practical Perimetry

September 22-24 — Contact Lens Seminar

October 26 — Diabetes Seminar

October 31 - November 23 — Board Refresher Course in Psychiatry

November 17 — Muscular Dystrophy

* * *

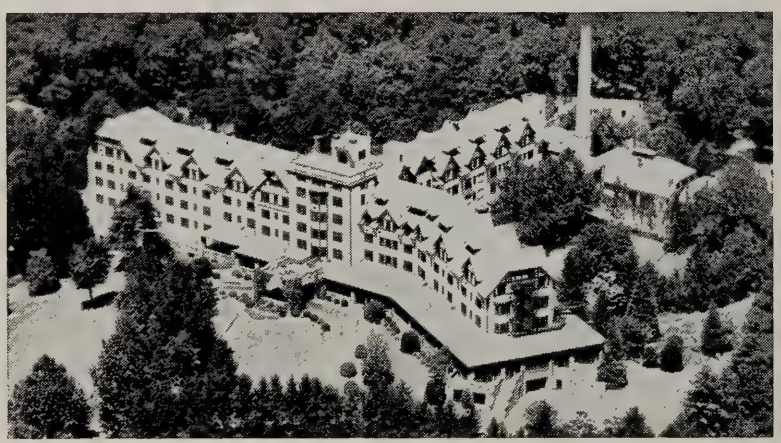
Four physician faculty members in the Ohio State University College of Medicine were promoted to professor effective July 1.

They are: Dr. Robert J. Atwell, Department of Medicine; Dr. William A. Newton, Jr., Department of Pathology; Dr. Martin D. Keller, Department of Preventive Medicine; and Dr. Howard D. Sirak, Department of Surgery.

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ESTABLISHED 1916

Asheville, North Carolina



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients

Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

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For rates and further information write APPALACHIAN HALL, Asheville, N. C.

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for the infant who requires a milk-free diet!



- Soyalac satisfies! Baby is happy, mother is grateful, doctor is gratified.
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- Soyalac is strikingly similar to mother's milk in composition and ease of assimilation. Clinical data furnish evidence of Soyalac's value in promoting normal growth and development.
- Excellent for regular infant feeding, too—and for growing children and adults.

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Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

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MEDICAL PRODUCTS DIVISION

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U. S. A.

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M.D., M.P.H.*

PART II

(Continued From July Issue)

THE importance of school nursing was everywhere being stressed "the value of their work being immediately demonstrated." Fifteen public and six parochial schools "are presently supplied, eight more than were supplied in the previous year," Dr. Landis reported.

1911

A total of nearly 14,500 specimens were examined in the Public Health Laboratory, an increase of over 79 per cent over the previous year. The improvement, in consequence in the quality of the milk supply, "is shown both chemically and bacteriologically . . ."

An outbreak of poliomyelitis in 1911 caused the city much worry. There were 103 cases with 38 deaths.

The opening of "the first open-air school" was heralded by Dr. Landis as "the most important step in the anti-tuberculosis campaign . . ."

In 1912, according to the Bureau of the Census, Cincinnati had an estimated population of 394,650. The death rate that year was 16.34 per 1,000 population, and the birth rate per 1000 live births was 19.93.

The district physicians were placed on full time in 1912, marking "the completion of a plan of reorganization begun shortly after the new Board assumed control in 1909 . . ." But this was not for the first time. There was a time in the 1880's when they had also been on full time.

The School Nurse

Dr. Landis, quite enthusiastic about the role of the school nurse in promoting the health of the school child, wrote in his annual report in 1912:

> The school nurse is the connecting link between the school and the home. She is the teacher of parents, pupils and families in practically applied hygiene. Her work prevents loss of time on the part of the pupil by reducing the number of exclusions for contagious diseases. Many minor ailments, when properly treated by the school nurse, will not prevent the regular attendance of the child. She gives practical demonstrations in the homes, or required treatments and frequently finds the source of the trouble, which if undiscovered, would render useless the work of the school physician.

Summer Pure Milk Stations

"The value of the Summer Pure Milk Stations" Dr. Landis wrote, "demonstrates that the milk station baby has a better chance for life during the hot months than the baby of parents of average means . . . 'Pure milk for babies of all classes' would not be a bad slogan . . ."

1912

Among other matters of interest during 1912, Dr. Landis noted that "three midwives were prosecuted for failure to report promptly gonorrheal infection in the newborn . . ."

The Cincinnati Association for the Blind he praised for "excellent service rendered not only to afflicted individuals but to the community at large. Several lives have been saved and 27 newborn babies were rescued from a possible life of blindness . . ."

The Tuberculosis Dispensary operated conjointly with the Anti-Tuberculosis League had done excellent constructive work. One thousand new patients were examined; 5,700 home visits were made by the nurses. But a survey of all cases

> ascertained that the Municipal Hospital (Dunham) had been the dumping ground for tuberculosis patients from our sister cities . . . All cases reported are now investigated and no patient may be admitted to the Municipal Hospital unless he has had an admission card signed by the district physician.

In regard to the control of communicable disease, and shades of a salaried medical service under socialized medicine, Dr. Landis wrote,

> The surveillance over communicable diseases by men engaged on "full time" has proven eminently more satisfactory than the old way. The district physician cannot now be accused of having ulterior motives and as a result, the feel-

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.
Submitted March 16, 1966.

ing of the general practitioner toward the Health Department is most friendly . . .

According to Dr. William H. Peters, the chief School Medical Inspector,

dental inspection in our public and parochial schools was carried on under the supervision of the Cincinnati Dental Society. Examinations were carried out in 24 schools, and nearly 12,000 children were examined and referred to private dentists or to the Cincinnati Dental Clinic. There were 902 children treated at the Free Dental Clinic. An experimental class was maintained in the Sixth School District to show the necessity as well as the results which may be obtained by proper hygienic mouth conditions . . .

In 1912 a system of barber shop inspections was instituted. Bake shop inspection had been inaugurated the previous year.

In 1912, there were 70 arrests and prosecutions made for expectorating on the street cars and sidewalks.

Nearly 2,000 privy vaults were cleaned out, abandoned and filled with fill during the year, and 857 sewer connections were completed.

During the year, visits to immigrants and the majority of fumigations were carried out by the Medical Inspection Division.

The passage of a pasteurization requirement, making it mandatory that all milk "not obtained from tuberculin tested cows be pasteurized" was a singularly important event.

A survey of tuberculosis cases during July and August revealed the fact that

many patients have been attracted from outside the city by the prospect of free treatment in the Tuberculosis Hospital, which condition unquestionably contributes materially to our heavy death rate fom this cause . . .

Dr. C. Bahlman, the Department's Chemist and Bacteriologist, noted that "all prosecutions have been carried into the Police Court. Very satisfactory results were obtained. Of the 86 cases, 65 were convicted. The total fines assessed amounted to $3,325."

1913

An ice-strike during the summer forced the city to place $5,000 to the credit of the Health Department and the Council authorizing the Department "to buy, sell and deliver ice to the people . . ."

In an inter-city study of departmental organization, etc., "the impression was received that the Cincinnati Department of Health has set a much higher general standard for appointment and service than any of the cities answering the letter of inquiry . . ."

On tuberculosis control Dr. Landis wrote deploringly,

The slight effort of the various agencies engaged in anti-tuberculosis work on the death rate seems to indicate the advisability of employing other and additional methods in combating it. The employment of an additional district physician who shall devote his entire time to the epidemiological study of this disease, is suggested . . .

On a need for improved industrial hygiene, Dr. Landis pointed out that

this is of enormous importance to workmen, employees and taxpayers. Many cases of disability and not a few deaths could be prevented by employing experts to detect and correct unsanitary conditions in workshops and factories . . .

On venereal disease Dr. Landis was "pleased to report that since the work of locating and quarantining cases in the hospital was begun, fewer advanced cases are treated in the hospital and clinics and fewer new cases are applying for treatment in their private practice . . ." Two district physicians were placed on "detached service" to investigate industrial hygiene and to locate and quarantine actively infectious cases of V. D.

There were 14 school nurses in the Department's employ in 1913 but the demand for an increase in this service continued.

A sanitary inspector "to cover the suburbs" had been given a motorcycle for this purpose. However, he had been involved in an accident and "this mode of transportation was therefore abandoned."

Need for Better Pay Stressed

Dr. Landis wrote with some vehemence on the fact that higher pay was attracting men from the Division of Food Inspection into the Federal agency concerned with this work. He also noted that "lack of funds is limiting the scope of usefulness of the laboratory." "No research work can be attempted because of the mass of routine work . . . The salary of the Bacteriologist should be increased and an assistant provided . . ."

Dr. Peters, the Chief School Medical Officer, noted that there were over 1,000 new cases of tuberculosis during the year, 459 of them sent to the Tuberculosis Hospital and 12 to St. Francis. The dispensary operated jointly by the Health Department and the Anti-Tuberculosis League served as a clearing house for these patients.

On prostitution, Dr. Landis wrote:

During the month of February, 224 inmates of 49 houses of prostitution were examined . . . 65 per cent of those found diseased were carrying on their occupation with certificates of health received by legally qualified physicians. All diseased prostitutes were sent to "O" Ward at the City Hospital. Certificates are misleading, giving a false sense of security to patrons . . . and are responsible to some extent for the spread of V. D. Common decency and the general welfare of the public demands the wiping out of this pernicious system . . .

The total number of sick poor seen by the district physician was 4,428. "In our efforts to minimize charity, 96 were sent to family physicians. During the year, 266 cases were referred to the visiting nurses of the Department for the Prevention of Blindness . . ."

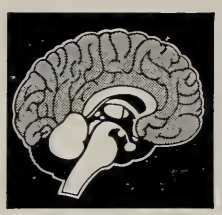
The average daily attendance at the eight Milk Stations during the summer was 441. Twenty thousand pamphlets on baby care were distributed. "Through the generosity of Mrs. Charles P. Taft, 25,500 pints of milk were sold at cost and 12,300 given away . . ."

(To Be Continued in September Issue)

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.


"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

OSMA Executive Secretary Is Named On Two National Committees

Hart F. Page, Executive Secretary of the Ohio State Medical Association, has been named to a newly organized liaison committee between the Medical Society Executives Association and the American Medical Association.

The MSEA-AMA Liaison Committee was created after months of planning on the part of MSEA officers, Dr. F. J. L. Blasingame, Executive Vice-President of the AMA, Aubrey Gates, director of AMA Field Services, and other AMA personnel.

The purpose of this new committee is to contribute to the improvement and strengthening of relationship between AMA staff members and executive personnel of state and county medical society headquarters offices. The committee will meet several times a year with AMA staff personnel on the division level.

The Medical Society Executives Association is an organization of executive secretaries and other executive personnel of state and county medical societies, and related groups.

Mr. Page earlier this year was named a member of the Advisory Committee to the Director of the AMA's Communications Division. This nine-man committee of medical society executives also meets several times a year, goes over plans for the public relations activities of the AMA, and provides advice to the director of the Communications Division on other matters.

Grand prize winner among 69 exhibits shown at the recent 61st annual American Urological Association meeting in Chicago was an entry from the University of Cincinnati Medical Center Division of Urology. Dr. Arthur T. Evans, director of the Division, and Dr. Joseph M. Malin, Jr., chief resident in urology, prepared the exhibit, "A Teaching Aid to Prostatic Surgery."

Blue Shield Symbol Protected By Appeals Court Decision

The National Association of Blue Shield Plans won a key court decision to protect the Blue Shield name and symbol.

According to NABSP, the Fifth United States Circuit Court of Appeals on June 16 reversed a lower court decision permitting the United Bankers Life Insurance Company, a Texas firm, to use the name and symbol "Red Shield."

The higher court ruled that the words and the symbol "Red Shield" are confusingly similar to Blue Shield. United Bankers is selling its "Red Shield" health insurance in competitiotn with Group Medical & Surgical Service, the Texas Blue Shield Plan which was a coappelant in the suit.

The National Association of Blue Shield Plans is the national coordinating organization for the 74 Blue Shield Plans in the United States that provide prepaid medical and surgical care benefits to 53 million persons.

Life Insurance Medical Research Fund Sponsors Grants and Fellowships

The Life Insurance Medical Research Fund will award more than $1.5 million in scientific grants and fellowships during the coming year.

A total of 58 medical research projects will receive grants during the 1966-67 academic year. New fellowships will go to 20 unusually promising medical students.

The grants and fellowships are provided through the contributions of more than 140 life insurance companies in the United States and Canada.

One of the research grants goes to Western Reserve University for studies by Dr. Harry Rudney on biosynthesis of isoprenoid precursors of cholesterol and ubiquinone; $33,000.

Fellowships go to two Ohio students: Karen R. Leininger, Columbus; and Scott E. Monroe, Cleveland.



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This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

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OSMJ

Scientific Section

VOL. 62 AUGUST, 1966 NO. 8

Palliation for Pelvic Carcinoma

A Study of Isolated Pelvic Perfusion With Chemotherapeutic Agents

ROBERT N. SWANEY, M.D., and WILLIAM G. PACE, M.D.

OVER the past three years, pelvic perfusion with chemotherapeutic agents has provided various degrees of palliation of pelvic pain secondary to advanced pelvic carcinoma. The perfusions were performed on 26 patients at the Ohio State University Hospital. Three patients were perfused a second time for recurrence of pain several months later. The procedure was selected because of recurrent carcinoma which was refractory to all other therapy. Most of these patients had been given maximum irradiation to the pelvis and many were addicted to narcotics for the control of pain.

Unfortunately, systemic chemotherapeutic agents are relatively ineffective in controlling pelvic pain. Chordotomy, especially for the control of bilateral pain, is fraught with complications.

Early attempts to isolate the pelvic circulation carried a high rate of leakage from the system. In 1962 Martin and White demonstrated excellent control of leakage in an isolated pelvic circuit. With the development of the abdominal-extremity tourniquet[1] isolation technique, we are now able to deliver high doses of chemotherapeutic agents to a localized area. Since this technique effectively isolates the blood supply from the rest of the body,[2] destruction of the bone marrow is no longer a threat.

Patient Selection

The original lesion in 16 patients was carcinoma of the cervix. It was in this group that the three reperfusions were performed for recurrence of pain.

Submitted October 5, 1965.

The Authors

● **Dr. Swaney, Columbus, is Resident in Surgery, The Ohio State University Hospitals.**

● **Dr. Pace, Columbus, is a member of the Attending Staff, Department of Surgery, The Ohio State University Hospitals; Associate Professor of Surgery, The Ohio State University College of Medicine.**

All patients in this group had had maximum irradiation therapy and some, radical hysterectomy. The universal complaint in this group was pain in the back, pelvis, or legs, which required a high degree of analgesic control. Hydronephrosis or complete ureteral obstruction was a constant finding and was usually located on the most painful side.

Five patients had pelvic recurrence from a primary carcinoma of the colon or rectum.[3] Some type of resection or diverting colostomy had been performed in this group. Pelvic pain and hydronephrosis were fairly constant findings in this group also.

In a miscellaneous group of five patients, two had carcinoma of the penis, two had recurrent melanoma and melanoma metastatic in the pelvis, and one had carcinoma of the bladder.

We have presently established strict criteria for patient selection. Body weight is the most important single factor. Application of the abdominal tourniquet in an obese patient has proven to be unsuccess-

ful. Ideally, a candidate should weigh approximately 100 pounds. The patient must have significant pelvic pain, which cannot be controlled with mild analgesics. Recurrent disease must be localized to the pelvis, and there must be no evidence of distant metastases. The disease must not be amenable to surgical or irradiation therapy. The general condition and cardiovascular status should be physiologically sound to withstand the procedure. Finally, the patient should exhibit good mental stability.

Technique

The Hartford Corporeal Tourniquet was used to isolate the pelvic circulation (Fig. 1). In the original work on pelvic isolation, the tourniquet was

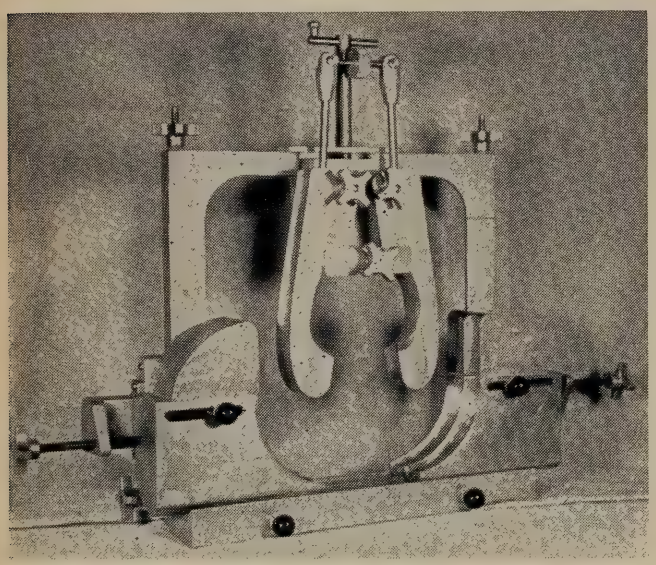


FIG. 1. *Hartford Corporeal Tourniquet.*

applied after a transabdominal incision was made to prevent the small bowel from being crushed by the tourniquet. This laparotomy has since been found to be unnecessary, and we now use a closed technique in which the tourniquet is applied to the intact mid-abdominal wall. The tourniquet effectively occludes the abdominal aorta, vena cava, and all soft tissue collateral arteries and veins. The epidural plexus is occluded by instilling saline under pressure through a radiopaque ureteral catheter placed in the epidural space. Bilateral mid-thigh pneumatic tourniquets complete the pelvic isolation (Fig. 2).

An extensive preoperative examination was carried out, evaluating for metastatic disease and determining the status of the urologic system by intravenous pyelography and cystoscopy. Contrast studies of the lower and upper gastrointestinal tracts were routine. Blood volume deficits were fully corrected. Four days before perfusion, the patients were given a nonresidue diet and a nonabsorbable intestinal antibiotic.

Prior to surgery, a small radiopaque ureteral catheter was positioned in the epidural space by a member of the Anesthesia Department. The location of the catheter was then confirmed by lateral roentgenograms and the injection of an appropriate contrast material.

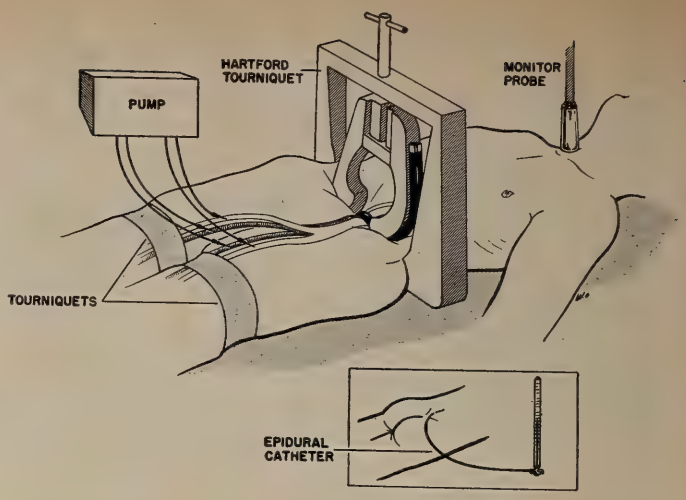


FIG. 2. *Diagramatic Sketch.*

At the outset of the operative procedure, clotting time was controlled with heparin. The femoral artery and vein of each extremity was then isolated and cannulated. Inflow and outflow circuits on both sides were necessary because occlusion of the aortic bifurcation by the tourniquet prevented adequate perfusion to the opposite side of the pelvis. The mid-torso tourniquet was then applied, and the pelvic circuit was started on bypass. The epidural catheter was simultaneously filled with saline, and a pressure of 30 cm. of water was maintained. The pneumatic tourniquets around the upper thighs were inflated to complete the pelvic isolation circuit.

A tracer dose of radioactive material was added to the perfusion circuit to monitor for possible leaks in the system.

Once isolation of the pelvis was confirmed, 5-fluorouracil, 20 mg/kg; methotrexate, 5 mg/kg; and phenylalanine mustard, 1.5 mg/kg were added to the perfusate and perfusion was maintained for one hour. Initially all three chemotherapeutic agents were used simultaneously; but in recent perfusions, the chemotherapeutic agents were limited to 5-fluorouracil and phenylalanine mustard. Periactin® was added to the perfusate in order to increase the blood flow to the tumor site. At the completion of the perfusion, the pelvic circuit was flushed with saline and albumin solution until the venous lines returned a clear solution. After complete washout of drugs, one unit of fresh whole blood was pumped back into the pelvic circulation.

When the Hartford Tourniquet was removed, there was invariably a transient fall in blood pressure. After initial stabilization, the leg tourniquets were removed, and the epidural space was decompressed.

Postoperative Morbidity

The morbidity associated with the pelvic perfusion is extremely low. One patient sustained a

mesenteric tear; this patient was of short stocky build and difficulty had been encountered in applying the tourniquet.

Postoperative ileus usually lasted 24 to 36 hours, which compares favorably with most major surgical procedures. Usually the patient had an onset of diarrhea toward the end of the first postoperative week and leukopenia was noted about the eighth to twelfth day. This usually resolved in four or five days. Most patients were ambulatory on the second postoperative day, and little or no analgesic control was required. In all cases the original pelvic pain was relieved.

Results

Over the past three years, 26 patients have been perfused by this method. The majority of the patients have had advanced carcinoma of the cervix. Three of these have had a second perfusion for a total of 29 perfusions.

In a total of 29 perfusions, there have been four deaths within 30 days. In all 29 perfusions, pelvic pain was completely relieved immediately after this procedure. The relief has lasted from several months to two years. During this period the patient has been able to live a reasonably comfortable and useful life. In some cases there was a disappearance of hydronephrosis which was secondary to ureteral obstruction by tumor.

Five patients have presented with advanced carcinoma of the rectum recurrent in the pelvis without distant metastasis. One member of this group is alive and well more than two years after perfusion. She has been able to maintain her full secretarial duties and is free of pain. Her pelvic mass has diminished since the time of perfusion. Her only complication was a colostomy stricture, which required revision six months after perfusion.

One patient died of toxicity and sepsis five days after perfusion. Difficulty had been encountered with both the tourniquet and the epidural catheter because of obesity. The perfusion had been discontinued when it became evident there was a moderate leak.

The last three perfusions do not have long term follow-up, but pain relief has been significant.

Summary

In the closed system outlined here, total isolation of the pelvis has permitted perfusion of the pelvis with chemotherapeutic agents up to 90 minutes with no evidence of leak. This procedure has been carried out 29 times in 26 patients. The results have been gratifying in that some selected patients with advanced pelvic carcinoma have enjoyed additional months of pain-free, useful living.

From the Department of Surgery, The Ohio State University Hospitals, Columbus, Ohio. Supported by a grant from the Hartford Foundation to the Midwest Foundation for Research and Education, Ohio State University Development Fund #521806, and in part by the P. H. S. Research Grant #FR-34, Clinical Research Center, Ohio State University Hospitals.

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Hippocrates

● *His was the torch from which a thousand fires*
Took flame and flourished through the ancient past;
Who flared the first of superstition's pyres
The knowledge of the doctors' world recast.
A true physician, worthy of his calling
And dedicated to his healing art,
He found the treating practices appalling,
And hastened to inject his wiser part.

● *His was the pen to set down rules of living*
That rightly followed must bring strength again:
A sound mind in a healthy body giving
The victory over suffering and pain.
His was the wisdom, born of inspiration
And nourished with foresight and common-sense,
That marked his path so every generation
Could follow in his steps with confidence.

— Marie Markle, 637 North Avenue, Dayton, Ohio 45406.

Brain Scanning

D. BRUCE SODEE, M.D.

RADIOISOTOPE brain scanning seeking surgically correctable lesions has become a recognized aid in diagnosis.[1-3] However, with the refinement in scanning equipment most investigators are now seeking the vascular anatomy of the brain as well as isolating brain tumors. This paper will present a simplified discussion of the scanning equipment, radiopharmaceuticals, and the technical factors pertaining to brain scanning so the practitioner can better understand this new diagnostic aid.

The Author

● **Dr. Sodee, Cleveland, is Director, Nuclear Medicine Department, Doctors Hospital and Renner Clinic Foundation, Cleveland, Ohio. Assistant Clinical Professor of Radiology, George Washington University, Washington, D. C.**

Scanning Equipment

Rectilinear Scanner

Many of the hospitals are equipped now with rectilinear scanners which traverse back and forth over the patient's head. These scanners utilize 3 by 2 inch, 5 by 2 inch, or larger sodium iodide crystals, which gather the isotopic data emitting from the patient. The information obtained may be displayed on film, on a cathode storage tube, or may be mechanically reproduced on paper. The defect of rectilinear scanning is that we are over an area a short period of time so that statistics or number of counts that we record coming from the patient may be limited.

Stationary Scanner

Stationary scanners are now under investigation in several institutions. The stationary scanner utilizes either a large diameter thin crystal or a large surface phosphor as the detector. The information obtained may also be displayed in several fashions. This system can record information much more rapidly than the rectilinear scanner. However, because of the large area being viewed, it is most difficult to bring out small lesions. Both of these scanning systems will be utilized clinically for brain scanning.

Radiopharmaceuticals

RISA I^{131} was one of the first successful radiopharmaceuticals for brain scanning.[4] However, its slow clearance from the blood delayed the brain scanning procedure for 24 hours. This radiopharmaceutical has been shown to localize in tumors. However, with overlying blood background small tumors may be missed.

Mercury 203 Neohydrin®. This compound replaced RISA I^{131} in most clinical laboratories three years ago.[1] Its rapid blood clearance and concentration in abnormal tissue made the finding of tumors much easier.

Mercury 197 Neohydrin®. This compound has largely replaced mercury 203 Neohydrin as approximately 10 per cent of the mercury administered is retained for a long time by renal tissue and the mercury 197 compound delivers much less radiation dose to the kidneys.[3]

Technetium 99m. This man-made six hour half-life nuclide formed in the degradation of molybdenum 99 is now undergoing clinical evaluation.[5] Tc 99m in the form of pretechnetate stays extracellular and therefore tumors can be seen because of their neovascularization. However, because of the intravascular concentration of this nuclide, some tumors will be missed because of the brain's normal overlying vascularity. This isotope gives an extremely low radiation dose to the patient. However, since it is not retained in tumor tissue, it lacks one of the diagnostic points of mercury 203/197 and RISA.

Positron Emitters. The positron emitters have been utilized at the large centers that had facilities for their production.[6] Since most of these emitters have short half-lives and are cyclotron produced, they have not been widely accepted as primary brain scanning agents.

Pathophysiology of Brain Scanning

We have found that all malignant brain tumors, as well as meningiomas, retain the mercurial compounds. Over the last four years we have primarily

Presented before the Ohio State Neurosurgical Society Meeting in Columbus, May 14, 1965.
Submitted for publication December 31, 1965.

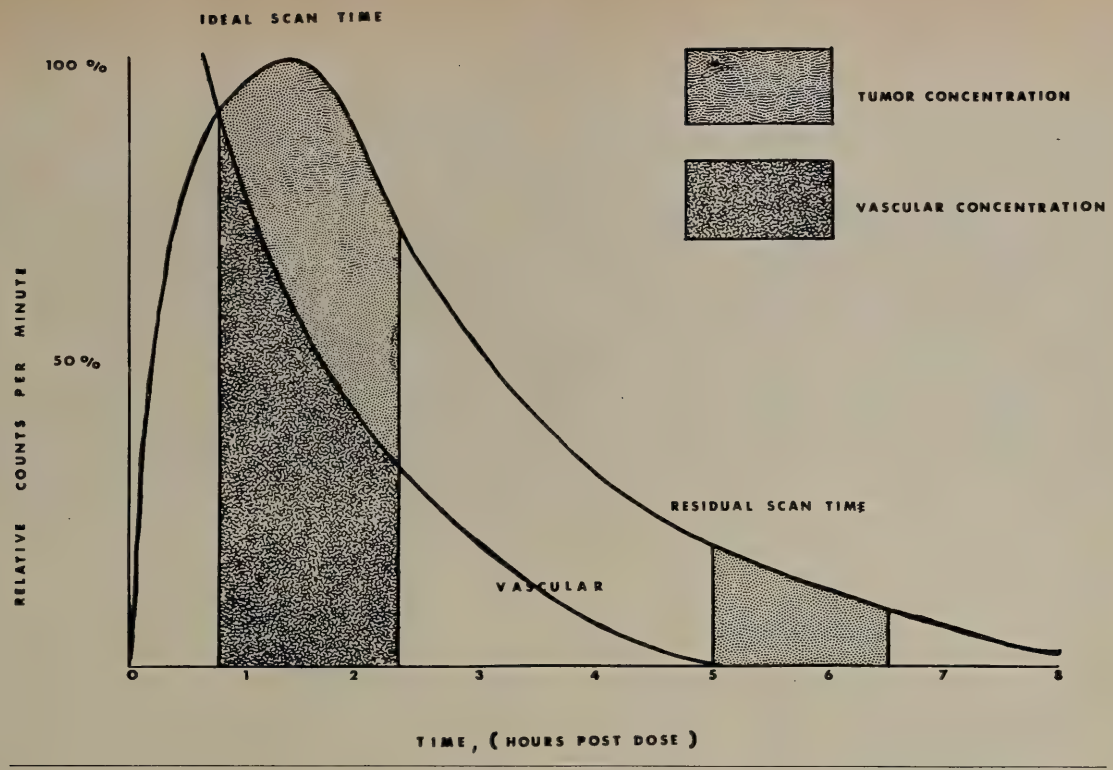


FIG. 1. *Relative Concentration of Isotope at Proper Scan Time.*

utilized mercury 203 chlormerodrin or mercury 197 chlormerodrin. You will note in Figure 1 that the majority of tumors concentrate the mercurial compound over a six hour period. However, the best scanning time has been found to be between one and two hours, as we visualize the mercurial concentration in the tumor as well as the neovascularity of the tumor. By scanning between one and two hours, we also see the normal vascularity of the brain as seen on scan (Fig. 2). If an abnormal concentra-

(Continued on page 803)

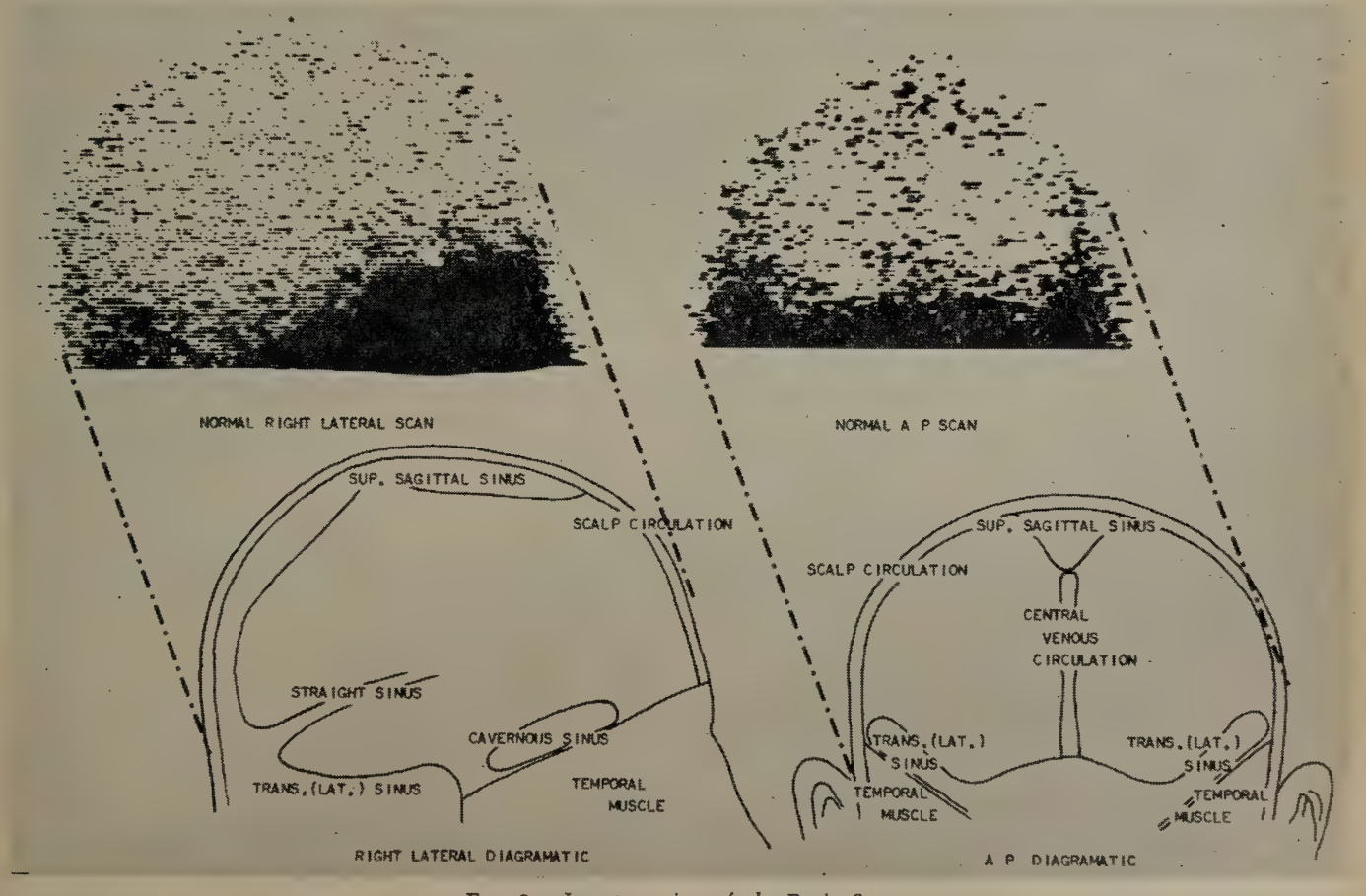
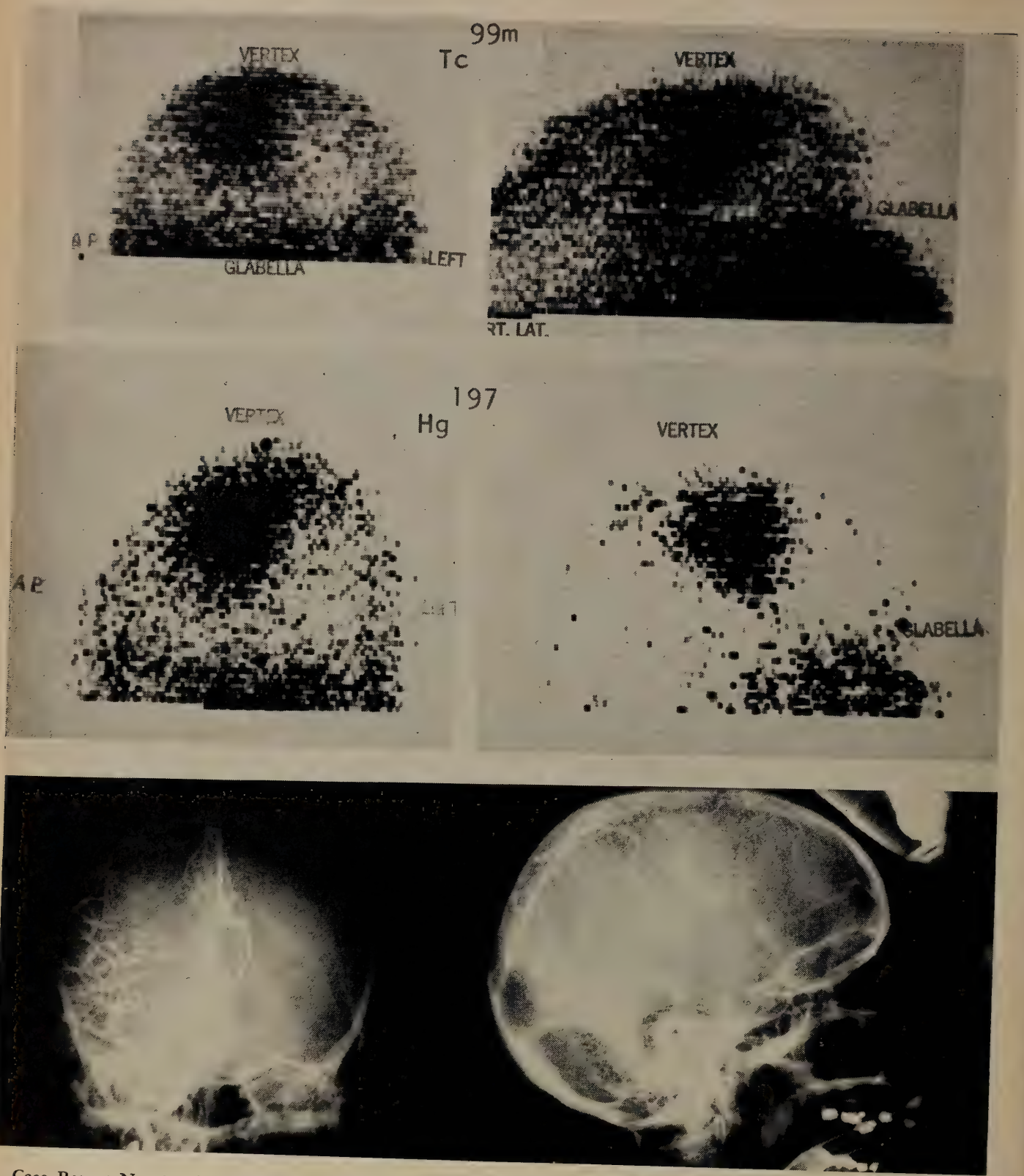
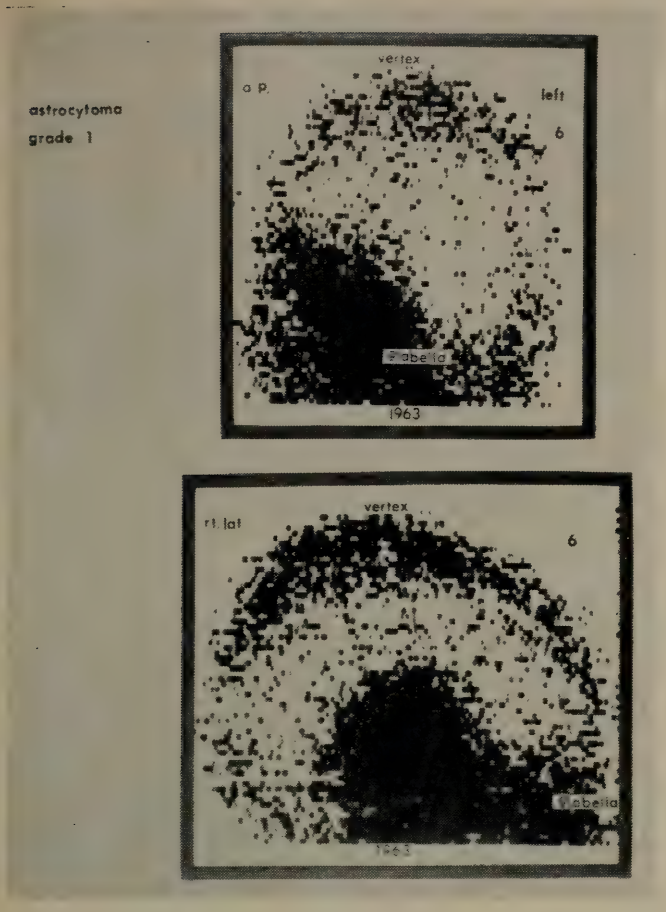
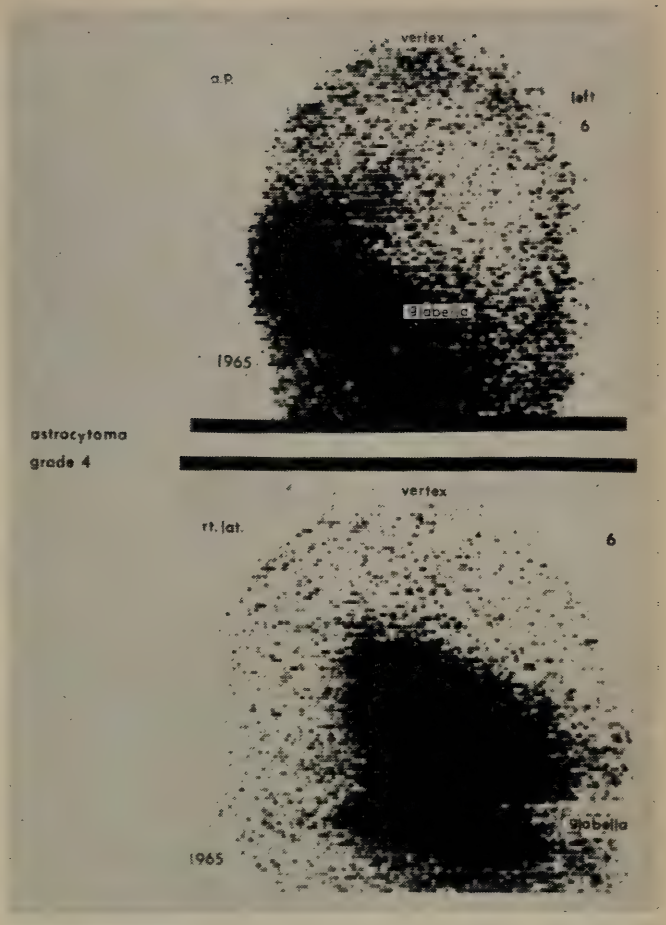


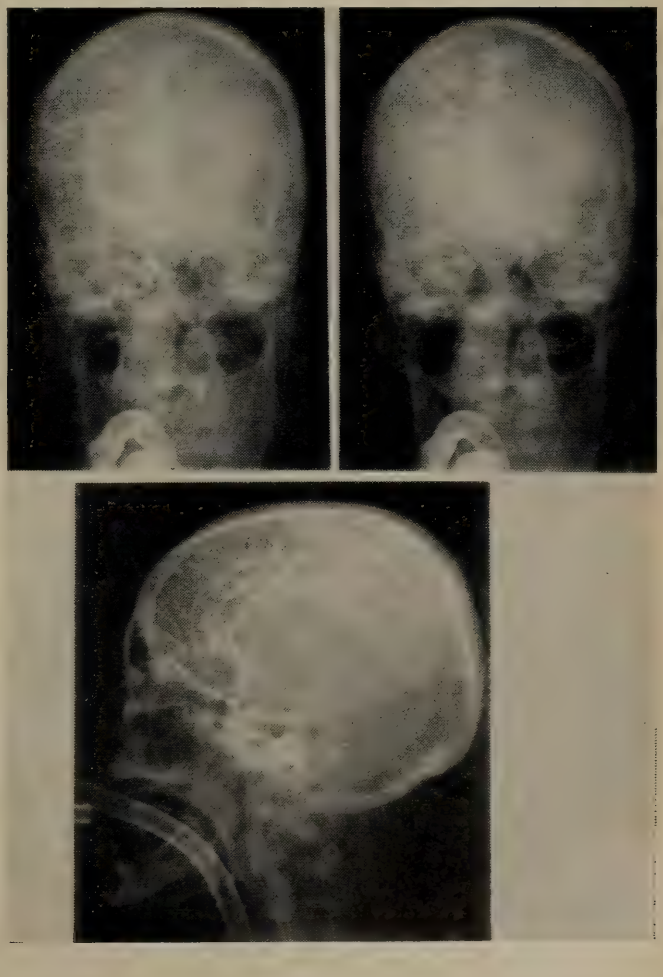
FIG. 2. *Interpretation of the Brain Scan.*



Case Report No. 1. A 35 year old white woman with a three week history of irremitent frontal headaches was admitted following a grand mal seizure. She was semicomatose, responsive to pain and areflexic with no other positive neurologic findings. Lumbar puncture revealed normal pressures and negative laboratory study of spinal fluid. The patient was nonfebrile and had normal hemogram and urinalysis. Blood urea nitrogen was normal. Initial rapid brain scan done with 1 millicurie of technetium 99m, administered intravenously, was abnormal, to the surprise of the clinicians concerned. The following morning, the patient was entirely normal with no abnormal neurologic findings, nonsymptomatic except for memory loss of the previous day. The mercury 197 chlormerodrin scan done was abnormal in exactly the same area as the technetium 99m scan. During the following week the patient remained nonsymptomatic and a repeat brain scan was still quite abnormal. Carotid arteriography revealed a mass lesion in the area described on scan. At surgery a meningioma was found and totally removed. The patient has had a complete recovery.

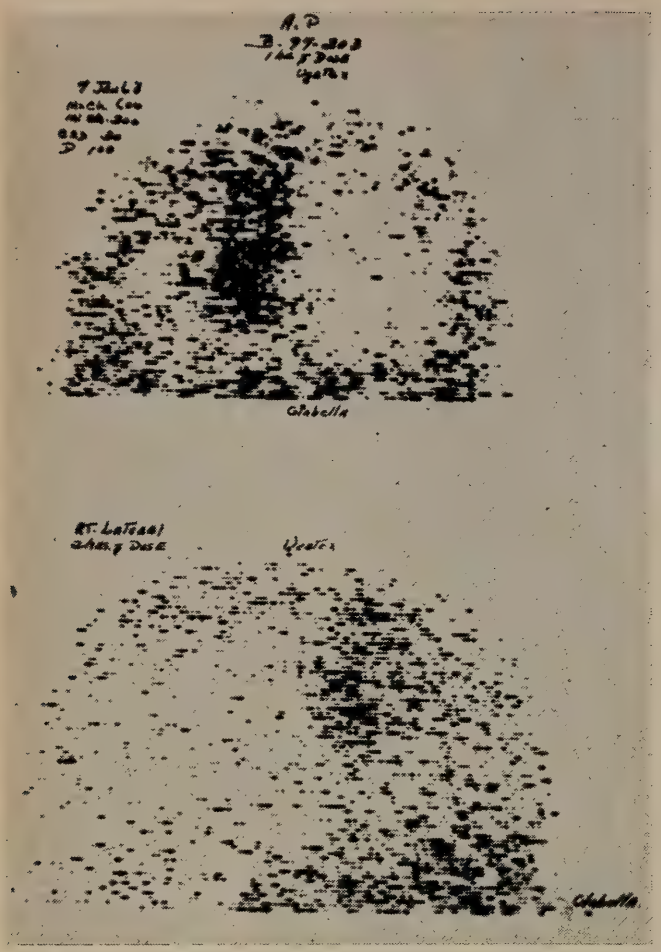




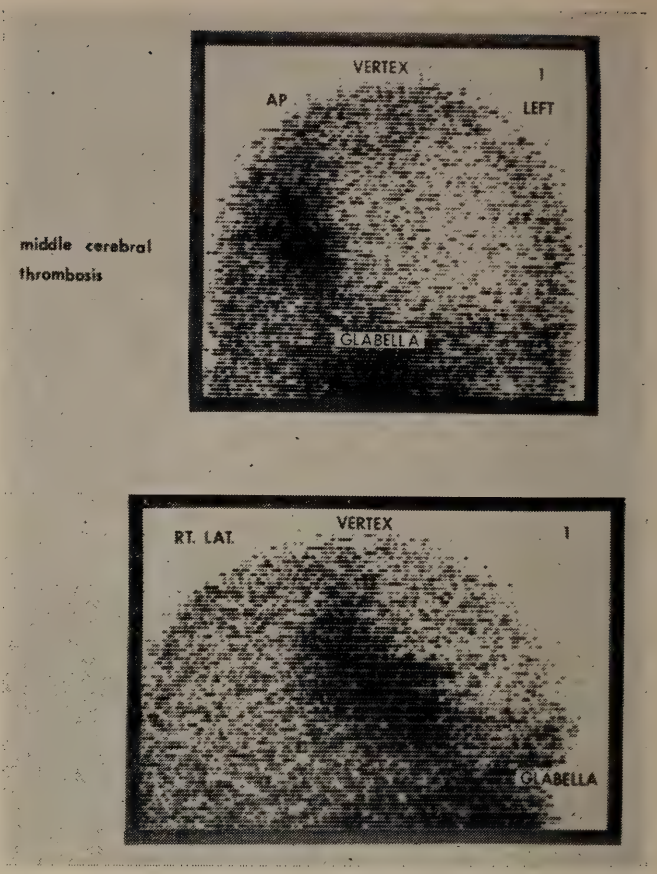


Case Report No. 2. A 45 year old white woman with a six month history of progressing left hemiparesis. Initial scan series revealed gross concentration of the isotope in the entire temporal lobe. At surgery an astrocytoma grade 1 was found and was thought to be totally removed. One year later the patient developed further signs and on re-scan the tumor can be seen to be across the midline and involving the parietal lobe on the right. Surgical biopsy revealed the tumor to be changed to a grade 4 astrocytoma.

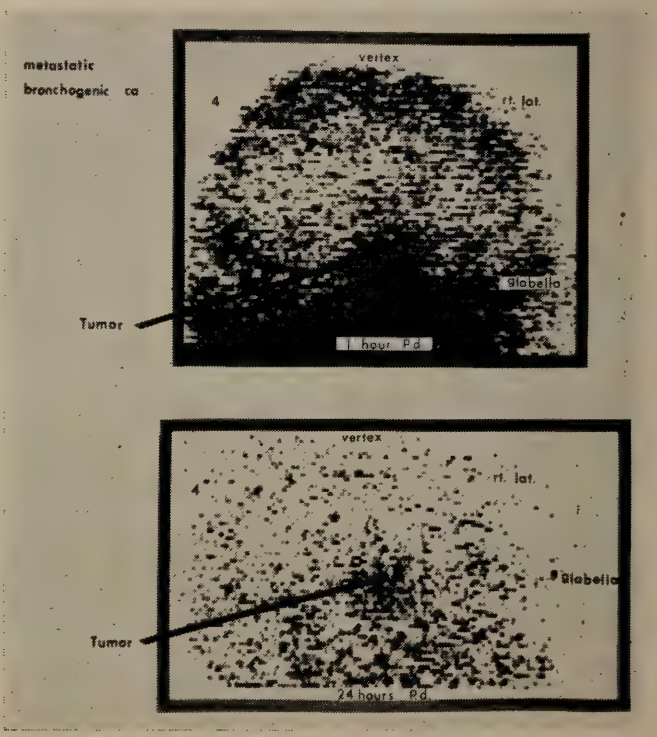
Case Report No. 3



Case Report No. 4



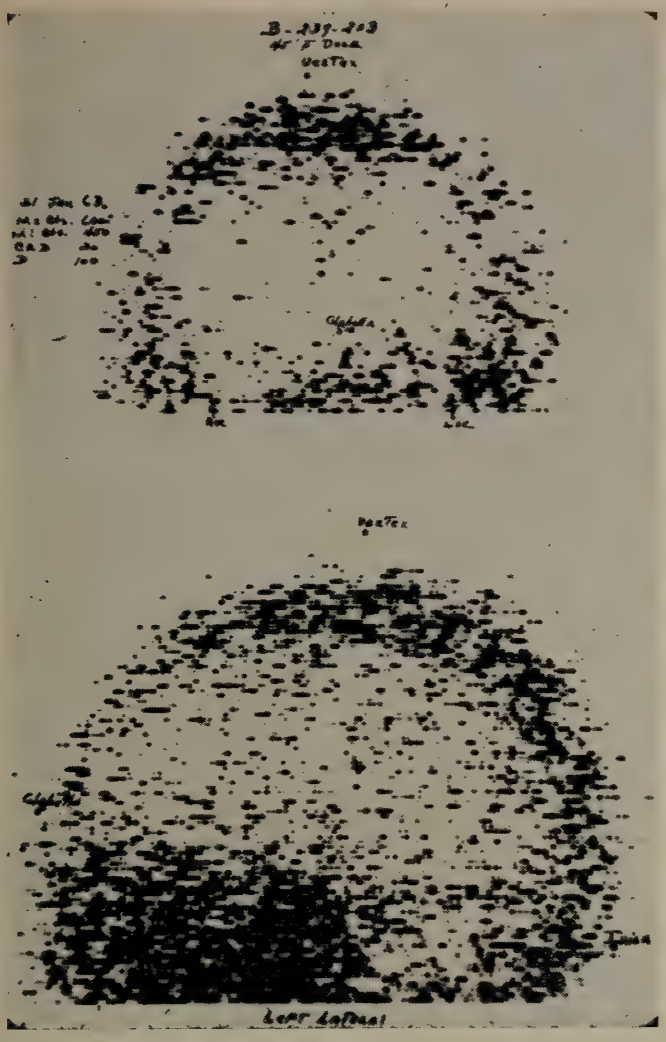
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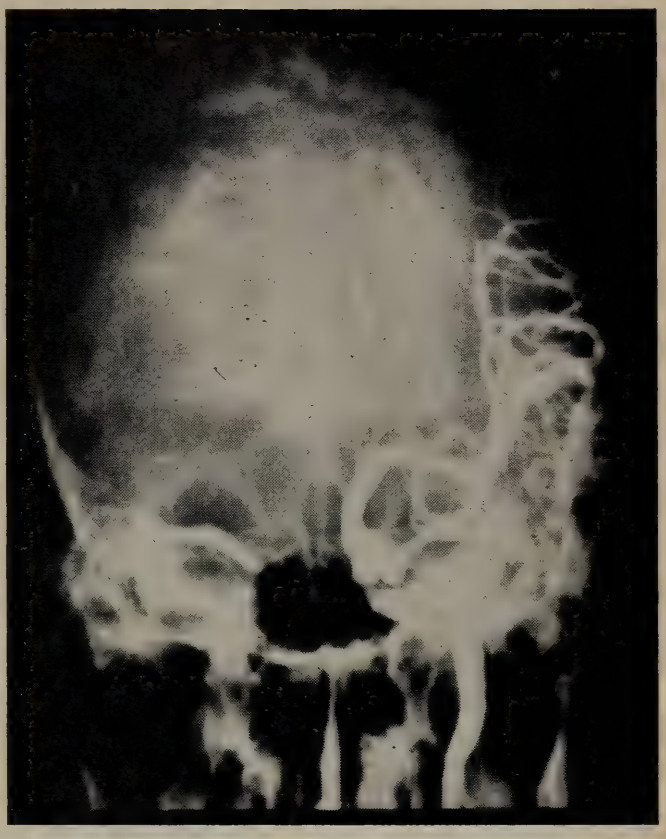


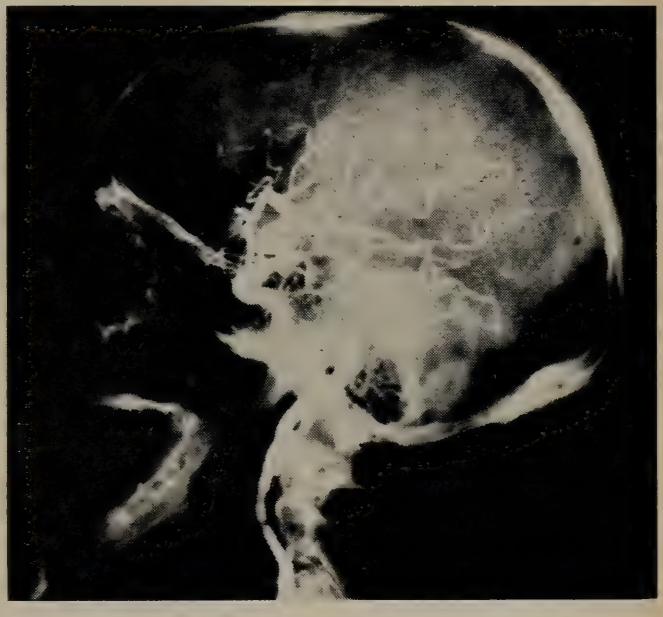
Case Report No. 3. A 42 year old white woman developed epilepsy six months prior to evaluation. Examination revealed the patient to have slight personality changes with left hemiparesis. The brain scan revealed a cystic-type lesion involving almost the whole of the right frontal lobe. At surgery this was proven to be cystic glioma.

Case Report No. 4. A 70 year old woman with acute signs suggestive of middle cerebral thrombosis. Scan revealed mercury retention throughout the area of vascularity by the right middle cerebral artery. Mercury is retained by the infarcted tissue and as the infarcted tissue clears, so does the mercury concentration.

Case Report No. 5. A 56 year old man with primary bronchogenic carcinoma surgically removed. Over a ten day period the patient developed ill-defined personality changes. Scan revealed a 3½ cm lesion in the right temporal lobe.







Case Report No. 6. A 50 year old man with a ten year history of increasing frequency of left orbit headaches which recently had become associated with vertigo. Brain scan revealed increased vascular concentration particularly when on the left lateral view at the level above the sylvian ridge. On repeat scan five hours later all concentration had disappeared, therefore, the abnormality was thought to be vascular. Arteriograms revealed this to be an arteriovenous fistula.

(Continued from page 799)

tion is noted on these earlier scans we then re-scan the patient at a later time looking for the retained abnormal concentration of mercury. In this way we can differentiate between vascular and nonvascular abnormalities. In Table 1 are listed the disease processes that we have found where there is tissue concentration of mercury. As will be noted this includes so-called benign lesions such as meningiomas, cerebral infarcts, and abscesses.

TABLE 1. *Disease Processes that Accumulate Mercury*

Primary Malignant Tumors
Metastatic Malignant Tumors
Meningiomas
Vascular Lesions (hematomas, A-V malformations brain infarctions and abscesses)

The Brain Scan as a Screening Tool

The brain scan has been most useful in selecting patients for correctable surgery at the time when they have minimal symptomatology. All institutions that are now doing brain scans have found many examples of this type of patient. (See Case Report No. 1.)

Brain Scan as a Follow-Up Tool

Since the mercurial concentration in tumor tissue, this procedure has been useful in following the neuro-

surgical patient postoperatively and during radiation therapy. (See Case Report No. 2.)

The Brain Scan for Exact Localization

Many times the carotid arteriogram reveals displacement of normal arterial structures, but if there is lack of tumor stain the extent of tumor involvement is difficult to ascertain. With exact anatomical landmarks on the brain scan there is no difficulty making an exact estimate of a lesion's site, size or extent of infiltration. (See Case Report No. 3.)

The Brain Scan as an Estimate of Neurologic Loss Following Loss of Blood Supply

Mercury localizes in infarcted tissue, therefore, the extent of cerebral infarction and the longevity of the residue may be ascertained by brain scan. In small cerebral thrombosis where there is adequate collateral supply, mercury is not found to localize in the affected area. (See Case Report No. 4.)

Extent of Metastatic Involvement

With today's brain scanning technique, metastatic involvement of 1-2 cm. in size can be ascertained. This is of paramount importance in the management of primary carcinoma, such as breast carcinoma, and has been of great aid to the neurosurgeon as the localized cerebral metastases may be removed if there is expected longevity of the patient. (See Case Report No. 5.)

Vascular Lesions

The congenital AV malformations are usually quite large and may be easily seen on the earlier brain scanning views. Subdural hematomas are one of the easiest neuropathological lesions we have to recognize. (See Case Report No. 6.)

Discussion

Isotopic brain scanning is now an accepted screening test and is now being widely utilized by the general practitioner, neurologist, internist, and neurosurgeon. This available isotope scanning procedure has no patient morbidity and gives valuable clinical information. Patients with the earliest of neurologic symptoms or behavior disorders may be found to have correctable neurosurgical lesions at a stage in their disease where a cure might be possible. In cerebral vascular disease valuable information as to the status of the vascular supply of the brain may be inferred by the brain scan. One of the most valuable uses of this procedure has been the assurance that if the patient has a technically good normal brain scan, in all probability he does not have a neurosurgical lesion. Therefore, the referring physician and the patient may be reassured at a very early stage with no patient morbidity. With the advancement in the radiopharmaceutical and nuclear medicine instrument industry, the brain scanning procedure is one of the isotope procedures that is available on a routine screening basis.

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VIRAL CHEMOTHERAPEUTIC RESEARCH is a rapidly expanding field occupying the efforts of biologists, pathologists, biochemists, physiologists, and organic chemists. With this formidable armada, success should be just around the corner; however, one wonders if the wily virus might not be just one step ahead of us, changing its coat as the climate demands. Many viruses, both DNA and RNA viruses that have been found affected by antiviral agents, are rapidly altered to a resistant state in the presence of the drug. The importance of these findings must await widespread use of viral chemotherapeutic drugs.

From past experience one must conclude that viral chemotherapy is a definite probability. The nature of the "antiviral" activity for the common upper respiratory diseases must be such that it will find a broad, nonselective use. Fertile avenues of approach appear to be prevention or amelioration of symptomatology, stimulation of nonspecific cellular defense mechanisms, and interference with enzyme systems common to many viruses. In addition, a more thorough understanding of the virus disease process, of methods of concentrating drugs in desired tissues and cells, and of the mechanisms of recovery from viral diseases will ultimately aid in the conquest of these diseases. — D. A. Buthala: *Annals of the New York Academy of Sciences,* 130:17-23, July 30, 1965.

Obesity

Phenmetrazine Effect Without Dietary Restriction

JOHN R. HUSTON, M.D.

THE objective evaluation of an oral anorexiant is often complicated by factors which may lead to invalid conclusions of efficacy. Most investigations have been carried out with little attention given to the influence of dietary restriction, motivation, and psychotherapeutic support from physician or nurse. Another critical factor is the reliability of the patient's adherence to prescribed medication.

The present controlled study is an attempt to overcome such limitations by using unrestricted diets and eliminating motivational elements. In an effort to attain ideal testing conditions, an appetite depressant was studied in a group of obese women living in an institution where environmental and subjective variables could be substantially controlled.

Phenmetrazine (Preludin®)*, an oral anorexiant of wide clinical use over the past decade, was chosen for this trial. The drug is a sympathomimetic amine belonging to the oxazine group of compounds. Pharmacologic studies[1] confirmed by later clinical trials[2-6] have shown that, in prescribed doses, it produces effective appetite suppression and weight reduction with comparatively few side effects.

Materials and Methods

A double blind cross-over study, using phenmetrazine and placebo, was performed in 33 obese, mentally defective women 16 to 64 years of age. The majority were 25 to 44 years old. Their I. Q.'s (Binet-L or Wechsler Adult Intelligence Scale) ranged from 26 to 77 with an average of 55. They received the ordinary diet (3000 to 3500 calories) served to all residents of the institution. As a group they appeared indifferent to their obese condition and during their residence made no effort at any time to reduce.

Patients were divided randomly into two groups approximately equal in size. Since some patients were transferred, only 33 remained to the end of the 30-week study, with 21 in Group I and 12 in Group II. However, as will be seen later, the unequal number of subjects in each group did not seem to affect the outcome of the study.

After a 5-week base line period, medication was administered once daily in the form of a phenmetrazine 75 mg sustained release tablet or identical placebo under two different code letters, A and B. Each group took the tablets in alternating sequence as shown in Fig. 1. Medication periods were varied from two to four to six weeks.

From the start of the study, weights were recorded once weekly on the same day and hour. In the middle 7-week period without medication, weights were just as carefully recorded for comparison with previous and later medication effects.

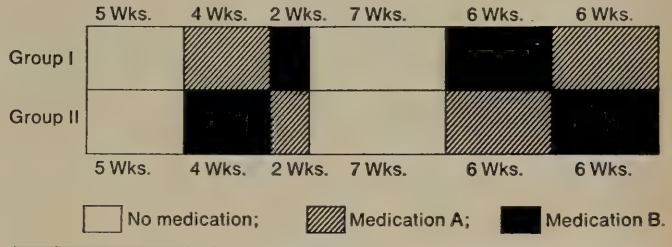


FIG. 1. *Sequence of medication.*

During the medication periods patients were brought into the medical office each morning after breakfast and received either one phenmetrazine or one placebo tablet from the nurse who made sure that the tablet was swallowed. Neither the investigator nor the nurse in charge knew the identity of the tablets. All patients were observed throughout treatment for possible side effects.

Results

Final evaluation showed that Group I (21 patients) had started medication with placebo, while

*Preludin®, 2-phenyl-3-methyl-tetrahydro-1, 4-oxazine hydrochloride, brand of phenmetrazine hydrochloride, Geigy Pharmaceuticals, Ardsley, New York.

From the Columbus State School, Columbus, Ohio.
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Group II (12 patients) had received the active drug first. Compared to placebo, statistically significant weight losses occurred at the end of each phenmetrazine treatment period in each group (Figs. 2 and 3).

In *Group I,* initial weights had varied from 151 to 245 lbs. in individual patients and averaged 180.4 lbs for the group. Weight dropped slightly at the end of the 5-week period without medication to a mean of 179.4, showing an average loss of 0.20 lb. weekly. The reason for this small weight loss is unknown, but it may possibly be due to a slight motivation effect produced by the weekly weighings.

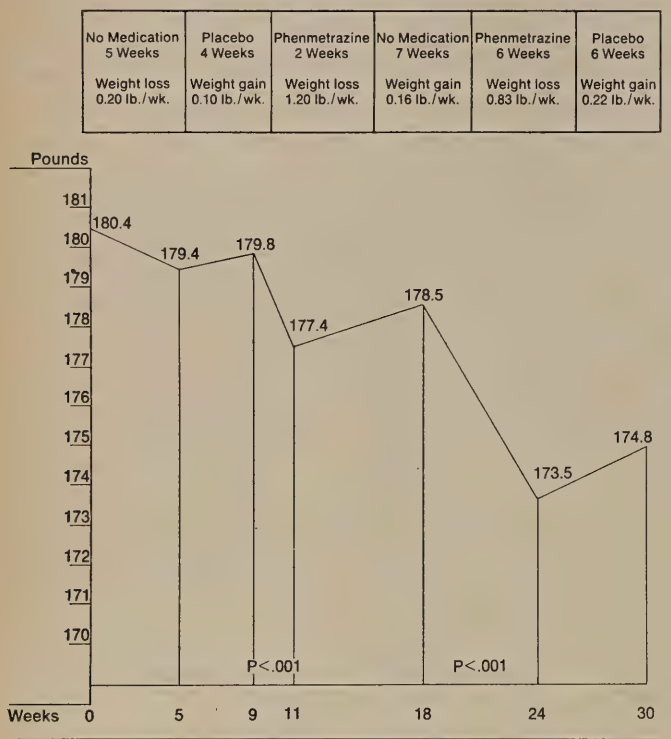


FIG. 2. *Group I (21 patients). Average weekly response of weight.*

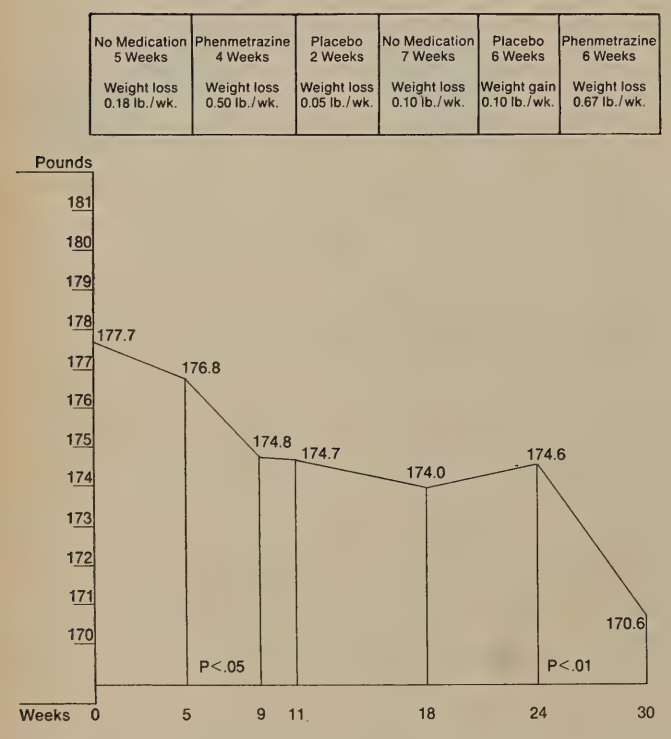


FIG. 3. *Group II (12 patients). Average weekly response of weight.*

After four weeks on placebo, average weight increased 0.10 lb. weekly. In the following period of two weeks on phenmetrazine, weight loss was 1.20 lbs. weekly. During the subsequent 7-week period without medication patients very slowly regained some weight at the rate of 0.16 lb. each week, which was slightly above the weekly gain on placebo. When the drug was resumed, weight loss averaged 0.83 lb. weekly for the 6-week period. In the final six weeks on placebo, weight again increased by 0.22 lb. per week.

Group II which had started medication on phenmetrazine showed a slightly different, though significant, pattern of weight loss on the drug. In these patients initial weights ranged from 138 to 252 lbs., with an average of 177.7 lbs., which decreased slightly to 176.8 lbs. at the end of the 5-week period without medication. This was a loss of 0.18 lb. weekly, comparable to the 0.20 lb. in Group I for the same period.

In Group II, the first course of phenmetrazine was four weeks, with a mean loss of 0.50 lb. weekly. In the following 2-week placebo period, weight decreased almost imperceptibly by 0.05 lb. each week. The weight loss on the drug, compared to that on placebo, was significantly greater. During the 7-week period without medication, slight weight losses were also noted. In the following six weeks on placebo, weight gain occurred at the rate of 0.10 lb. weekly. The final 6-week drug period showed a significant loss of 0.67 lb. weekly compared to the 0.10 lb. gain on immediately preceding placebo dosage for a similar period.

Comparison of the 6-week drug periods showed an average weekly weight loss of 0.83 lb. in Group I and 0.67 lb. in Group II.

Throughout the study no side effects were reported or observed in any patient.

Discussion

Results showed that phenmetrazine produced significant weight losses in both of the groups treated, while placebo exerted little or no effect. The care taken to eliminate or control known factors which might bias the result further supported the efficacy of the drug. At no time during the study did the physician or the nurse in charge discuss the subject of weight reduction with the patients or encourage them towards this end. Thus, psychologic factors commonly acknowledged to promote weight loss were reduced to a minimum, and the weight losses noted could validly be attributed to the drug.

In this regard, a recent interesting study[7] showed that phenmetrazine significantly reduced food intake in subjects of normal intelligence only when they

were told that they might receive an appetite depressing drug. This expectation, however, did not significantly alter their food consumption while they received placebo. Perhaps, in our study, the regimen of daily medications and weekly weighings subtly produced the same result as would be obtained by telling patients they might receive an appetite depressant drug. However, it is unlikely that our mentally retarded group would be affected to the same extent as persons of normal intelligence.

While greater weight losses than those observed in our study have been reported[2,4] in patients treated in a physician's office where they are encouraged and motivated to lose weight, usually with the help of dietary restrictions plus an appetite depressant, this study demonstrates significant weight loss while patients received phenmetrazine alone. However, in each case on stopping phenmetrazine there was an abrupt alteration in the pattern of weight loss to insignificant amounts or, more frequently, to weight gain. This would indicate that phenmetrazine is effective only while being taken and does not alter the factors which produce obesity, at least as observed in the 2- to 6-week courses here employed.

Although poor eating habits which induce obesity can often be traced to some emotional problem, a decrease in caloric intake is necessary for sustained successful weight reduction. Since dietary restrictions alone impose an austerity leading to further tensions and irritability, the use of an appetite depressant is usually helpful. Physicians are in effect treating a symptom and ignoring the cause when they use only appetite depressants in the management of obesity. This study supports the concept that phenmetrazine is an effective *adjunct* in the comprehensive management of the overweight patient.

Summary

Phenmetrazine, an anorexigenic agent belonging to the oxazine group of compounds, was evaluated in a double blind cross-over study with matching placebo in 33 mentally retarded, obese women 25 to 44 years of age. Medication was administered once daily after breakfast, the drug being given in the form of a 75 mg sustained release tablet.

Factors conducive to biased results were eliminated as far as possible. The elements of motivation, expectation and psychologic support were reduced to a minimum. Diets were uniform and unrestricted and patients' adherence to prescribed medication was carefully supervised.

The study ran from 30 consecutive weeks, including an initial 5-week base line period and an interim 7-week period without medication. In two randomly divided groups medication was reversed after courses of two to six weeks.

Phenmetrazine was found to be an effective appetite depressant producing significant average weight losses of 0.7 to 0.8 lb. weekly over a 6-week period. Placebo exerted little or no effect and during some periods of the study produced a slight weight gain. No side effects were observed or reported.

Since diets were unrestricted and psychologic factors were virtually absent, the weight losses may be attributed to the action of phenmetrazine alone.

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SCHIZOPHRENIA. — Twenty male and 22 female schizophrenics were treated by conjoint family and milieu therapy in two mental hospitals with reduced use of tranquillizers. No individual psychotherapy was given. None of the so-called shock treatments was used, nor was leukotomy. All patients were discharged within one year of admission. The average length of stay was three months. Seventeen per cent were readmitted within a year of discharge. Seventy per cent of the others were sufficiently well adjusted socially to be able to earn their living for the whole of the year after discharge. These results are the first to be reported on the outcome of purely family and milieu therapy with schizophrenics, and they appear to us to establish at least a prima facie case for radical revision of the therapeutic strategy employed in most psychiatric units in relation to the schizophrenic and his family. This revision is in line with current developments in social psychiatry in this country. — A. Esterson, M. B., CH. B., D. P. M.; D. G. Cooper, M. B., CH. B., D. P. M., and R. D. Laing, M. B., CH. B., D. P. M., London, England: *British Medical Journal,* 2:1462-1465, December 18, 1965.

Intussusception of Small Bowel On a Cantor Tube

Report of a Case

NOEL PURKIN, M. D., and SAMUEL S. TEITELBAUM, M. D.

THE occurrence of intussusception of small bowel on an indwelling intestinal decompression tube prompted a perusal of the literature on the subject. The surprising finding was that there have been only two other cases of this nature reported in the world literature to date.

Although the decompression tube has been in existence for over 40 years, few cases of complications arising from its use have been reported in recent literature. It is well known and remembered that there were many articles written about intestinal decompression tubes at the time of their inception, as well as many cases documenting the complications arising from their use. Cantor[2] and Harris[5] describe the many complications which may occur. Among these are laryngeal edema, intestinal perforation, distention, and intussusception. Harris[4,5] alludes to a further complication in which the mercury bag may rupture or fall off the tube.

Following the report of McGoon,[1] and Cantell and Warren,[3] Cantor[2] published a review on the effect of variation in the length of the decompression tube upon the bowel wall. It was felt that the ideal length would be that which would least interfere with the normal small bowel functions of motility, secretion, and absorption. If the 4 foot tube was permited to pass down into the gastrointestinal tract and the tube was then fastened to the face with adhesives, the vigor of the peristaltic activity would be noted to result in an intussusception-like effect, and the bowel would pleat tightly on the tube. The shorter the length of tube down the bowel, the tighter the plication on it. The incidence of intussusception appeared directly proportional to the tightness of the plications.

It was Cantor's conclusion that the position of the tube head was extremely variable, regardless of the length of the tube down the bowel. The only accurate method of localization was by means of x-ray. He also stated that the intestinal decompression tube should never be fastened to the face of the patient and that permitting the tube to pass downward only as fast as the peristaltic activity or pull of the tube head would allow resulted in the smallest degree of plication of the bowel and hence the least interference with the normal physiology of the bowel. It was felt that 6 to 10 feet of intestinal tube interfered least with peristaltic activity and produced the least plication. In the event that the tube were to remain within the bowel for any length of time, or were to be used for feeding, the 10 foot length of tube was found most suitable, because it resulted in the greatest surface area of mucosa available for secretion and absorption, and the least interference of peristalsis.

Cantor's findings seem to fit in well and support the pathogenesis of intussusception of the small bowel on an intestinal tube as postulated by McGoon.[1] McGoon purports that peristaltic waves act upon the bag at the end of an indwelling tube exactly as though it were a food bolus and force it distally within the intestinal lumen. However, the long tube trailing behind offers resistance to the forward movement of the bag, especially if the tube is anchored externally to the face. Since each action has an equal and opposite reaction and since the bag in the intestine resists distal propulsion, the intestine itself is, therefore, drawn proximally over the semi-fixed bag and tube. Repeated peristaltic activity may thus draw the entire length of the intestine proximally around the bag until it has telescoped over a length of tube many times shorter than the length of the involved intestine.

Under normal conditions, the adjacent peritoneal surfaces of each infolded pleat of bowel show no

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more tendency to adhere than do the normal adjacent loops of intestine. Consequently, on withdrawal of the tube, plication disappears and the intestine returns to normal status. When, however, intraperitoneal conditions which are conducive to adhesion formation develop—preceded by a fibrinous exudate on the serosal surface of the intestine, such as occurs in the postoperative phase as well as following peritonitis — the adjacent peritoneal surfaces of each plication may adhere. The fixed plication resembles, to some extent, an intestinal polyp with its intraluminal projection and its attachment to the intestinal wall and may produce and lead an intussusception. This also accounts for the possibility of an intussusception developing even after withdrawal of the intestinal tube. A failure to appreciate the complication which may arise was believed to have been responsible for the resulting fatality in one of the reported cases. It is also noted that the occurrence of this complication, following the use of an air-filled bag, was one of the factors which led Harris to experiment with the use of mercury. The treatment of this complication is surgical intervention by exploratory laparotomy, reduction of the intussusception, and resection if necessary, dependent on compromise of the bowel wall. Often, the Cantor tube may have to be withdrawn completely.

Case Report

The case being reported is that of a 41 year old Para III, Gravida III, white woman who was admitted with urinary frequency of increasing severity over a five-year period. Physical examination, aside from a marked cystocele and rectocele, was essentially not remarkable. Three days after admission, she underwent a vaginal hysterectomy and anterior and posterior repair. During surgery, the patient developed a period of moderate hypotension. A 500 cc. blood loss was replaced. A vaginal drain and pack were left in. Five days postoperatively the patient manifested a temperature of 101.4°F. (38.6 C.), a distended abdomen but with bowel sounds present, and brown vaginal bleeding. The following day her temperature was 100.0°F., her abdomen was still distended but with fewer bowel sounds, and an enema was fairly effectual.

The next day, one week postoperatively, her symptoms had increased and a Cantor tube was inserted. The patient was followed with serial abdominal films, with the radiologic impression of a paralytic ileus rather than a simple mechanical obstruction. Following insertion of the Cantor tube and its progression down the bowel, the radiologic appearance of the postoperative paralytic ileus improved. A chest film at that time showed no evidence of pulmonary infiltration. Two days after insertion of the Cantor tube, the patient received two courses of Prostigmine® 1:1000, 0.5 cc. at 20 minute intervals for a period of three injections, resulting in good bowel movements. Several hours later, she began to bleed vaginally and was taken back to the operating room, where the anterior repair was resutured. The surgical impression was that of an infected vaginal cuff hematoma.

The patient's radiologic and clinical appearance was greatly improved, and the Cantor tube was removed five days after its insertion. However, the day after withdrawal, the patient vomited 100 cc. of a brown, foul smelling material. The abdomen again became very distended and, although she had had a bowel movement that morning, the feeling was that she had redeveloped her ileus, and the Cantor tube was reinserted. Abdominal x-rays showed gas in the colon, and it was felt that the degree of ileus was not too impressive. However, three days after the reinsertion of the Cantor tube, the patient, still not greatly improved, was taken to x-ray for a barium study through the Cantor tube. Preliminary films showed no significant degree of bowel distention. The Cantor tube was in the jejunum to the right of the vertebral column, and a mechanical obstruction was not evident at this time. When the barium was injected, however, it was noted that there was a disparity of the lumen of the jejunum, with the proximal jejunum appearing more dilated than that of the more distal portion. The area of transition appeared to be just distal to the mercury bag. This, however, was transient in nature, and follow-up films taken several hours later showed the barium to have traversed the area, and the proximal jejunum to appear less dilated. The transit time appeared to be within normal limits. It was felt that the x-ray examination had demonstrated no complete obstruction to the passage of barium through the small bowel. However, it was believed that the alteration in the mid-jejunum would have to be correlated with the clinical findings (Fig. 1).

Two days after the x-ray examination, the patient had two bouts of emesis with colicky abdominal pain. While making rounds the previous night, the house officer had noted the Cantor tube fastened to the patient's nose with a piece of tape, and when this was released her complaints of abdom-

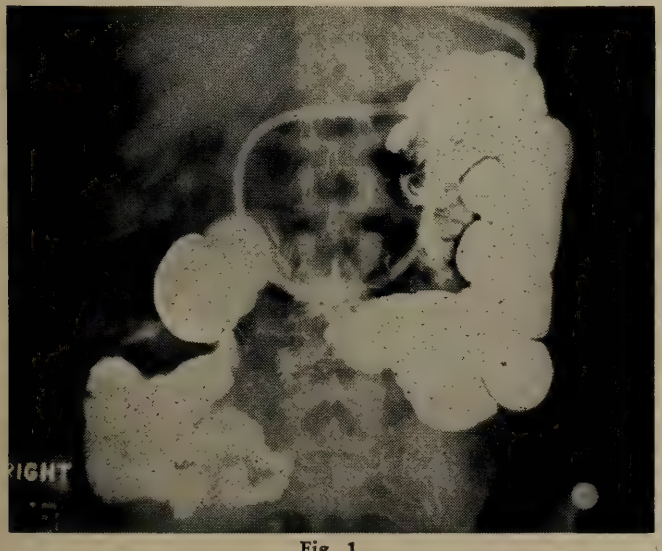


Fig. 1

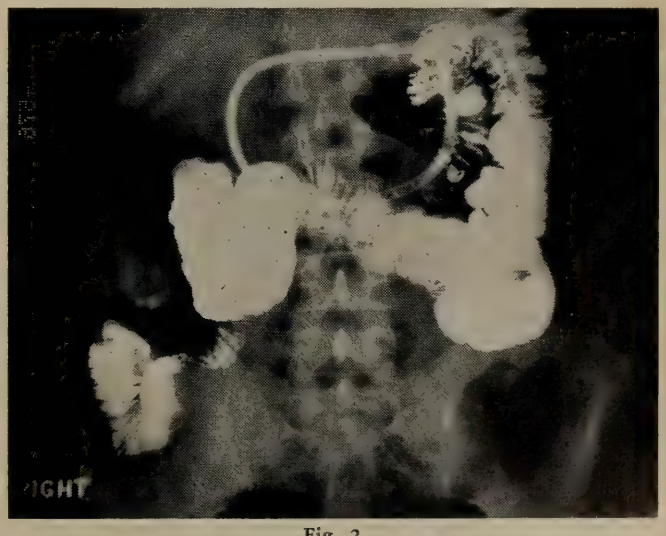


Fig. 2

FIGS. 1 & 2. *Abdominal films of barium swallow. Cantor tube in jejunum to right of vertebral column. There is a disparity in lumen of jejunum appearing just distal to mercury bag.*

inal cramps subsided to a great degree. A repeat x-ray was obtained, which showed stasis of barium with cecal dilatation and small bowel collapse (Fig. 2). It was the impression that small bowel obstruction was present, and the patient was taken to the operating room.

At surgery, dilated loops of small bowel were found, and there was a loop of dilated bowel that was tacked down to the posterior parietal peritoneum. The sigmoid colon was seen to be plastered over the vaginal cuff, but there was no abscess or hematoma. The Cantor tube could be felt well down in the small bowel. The dilated loop of mid-jejunum was delivered into the incision. It was markedly thickened and hard, measuring about 6 to 8 cm. in diameter and approximately 25 to 38 cm. in length. The Cantor tube was felt just below and above it. The feeling at this time was that this was an intussusception, which was reduced by gentle pressure distally on the mass. Following the reduction of the intussusception a perforation was seen in the involved small bowel. About 6 inches of the small bowel was resected, and an end-to-end anastomosis was performed. The bowel was then examined, and serosal tears of the cecum were plicated with No. 4-0 silk. Following this, the small bowel was re-examined and seen to be re-intussuscepting over the Cantor tube, which had been left in place. The tube was then completely removed and the intussusception was easily reduced. Postoperatively, the patient made an uneventful recovery and was discharged from the hospital 10 days later.

The pathologic specimen consisted of a piece of small intestine measuring 9 cm. in length. At one end, the external diameter was 2.8 cm. At the other end the external diameter was 3.5 cm. The external surface of the gut was shiny in places but congested. Part of the serosal aspect on one side was covered up by a fibrinous, white exudate. On the same surface near about the middle of the piece of intestine, there was an indurated area having an average diameter of 1.8 cm. The mucous membrane of the piece of intestine was congested, except over a linear area in the central part where it appeared white. Grossly, the mucosa and the wall of the intestine appeared edematous. Microscopic examination revealed marked hemorrhage and edema of small bowel with organizing fibrinous peritonitis.

Discussion

The reason for the intussusception in this case seems to fit closely to McGoon's pathogensis, ie, once the tube had been fixed to the nose, the patient complained of severe colicky pain and emesis, and it was postulated that this was the time that the pleats of bowel became tight and with the altered intraperitoneal conditions became adherent with one another with a resulting intussusception. It is salient to note that a 10 foot Cantor tube was used in this instance and the tube was seen to have been down approximately 5½ feet, so at least one of the principles propounded by Cantor[2] had been present. However, it further emphasizes Cantor's statement that one of the prime dictums in intestinal decompression tube usage is that the tube must not be fixed to the nose of the patient. The diagnosis in this case hinges upon the awareness of the possibility, though rare, of the occurrence of this type of lesion, plus a close x-ray follow-up correlated with clinical findings.

Summary

The case presented is that of a 41 year old white woman who, after vaginal hysterectomy and postoperative vaginal bleeding, developed paralytic ileus and a subsequent partial small bowel obstruction resulting from a small bowel intussusception secondary to intestinal decompression tube intubation. Diagnosis was made by clinical findings and x-ray evaluation. The patient required resection for a perforation of the bowel wall incumbent on the intussusception.

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ORAL CONTRACEPTIVES. — The exact mode of action of oral contraceptives is incompletely understood at present. It is suggested that the "classical" pill (various gestagen-estrogen combinations) has at least two points of attack: it inhibits ovulation by blocking the release of luteinizing hormone, and it renders the cervical mucus hostile to sperm penetration.

It is likely that the "sequential" pill inhibits ovulation by suppressing the release of both follicle-stimulating hormone and luteinizing hormone. Whether it also has an additional point of action cannot be decided at present.

Finally, the pill based on "low-level luteal supplementation" is capable of controlling fertility without inhibiting ovulation. In this case changes in the endometrium and/or cervical mucus may be responsible for the contraceptive effect. — Egon Diczfalusy, M. D., Stockholm, Sweden: *British Medical Journal,* 2:1394-1399 (December 11) 1965.

Pregnancy in Acute Leukemia

Report of a Case

T. D. STEVENSON, M.D., WILLIAM C. RIGSBY, M.D., and
D. P. SMITH, M.D.

ACUTE LEUKEMIA is a tragic and fortunately rare complication of pregnancy, which usually results in death of both mother and infant. Moloney in a recent review found 267 reported cases of leukemia occurring in pregnancy, and in 222 cases in which information concerning the type of leukemia was available there were 102 cases of acute leukemia.[1] Acute myeloblastic leukemia was the most common type encountered comprising 63 per cent of the acute leukemias. The reported cases of acute leukemia in pregnancy have increased in the past few years. This increase has been attributed to both increased case recognition and to an increasing incidence of the disease.[1,2] Acute leukemia usually occurs as a complication of an existing pregnancy. It is rare for a woman with acute leukemia to become pregnant.

We have studied a patient with acute myeloblastic leukemia who became pregnant while in remission of her disease. The patient was receiving an antileukemic drug at the time of conception and was maintained in a partial remission with chemotherapy throughout the course of pregnancy. She subsequently delivered a normal premature male infant. It is the purpose of this report to record our experience in the management of this patient and to comment on the use of antileukemic drugs in pregnancy.

Case Report

This 20 year old white woman was seen in May, 1963, complaining of recurrent ulcers in her mouth of approximately three months' duration. She had been well until February, 1963, when she first noticed a small ulceration on the tip of her tongue, which enlarged, became very painful, and was followed by similar ulcerations in the buccal mucosa. Local measures were not successful in controlling the ulcerations, and it was difficult for the patient to eat. Fatigue and weakness appeared and became severe.

On examination the significant findings were the presence of numerous small ulcers on the tongue and buccal mucosa, which were covered with a small amount of white exudate. The spleen was palpable 2 cm. below the left costal margin. There was moderate generalized lymphadenopathy. The remainder of the physical examination was not remarkable.

Hematologic study revealed: hemoglobin 10.8 Gm. per 100 ml., hematocrit 34 per cent, white blood cell count 15,900 cu.mm., differential polymorphonuclear leukocytes 11 per cent, lymphocytes 1 per cent, monocytes 35 per cent, myeloblasts 35 per cent, myelocytes "A" 3 per cent, eosinophils 15 per cent. A bone marrow specimen was aspirated from a spinous process and showed complete replacement of the normal marrow elements by myeloblasts, many of which contained Auer bodies (Fig. 1). The hematologic findings were diagnostic of acute myeloblastic leukemia, and the patient was given 6 mercaptopurine, 150 mg. per day.

The oral ulcers healed completely in two weeks. A decrease in the white blood cell count with an increase in mature granulocytes in the peripheral blood was noted after several weeks, and the 6 mercaptopurine was gradually reduced to a maintenance dosage of 50 mg. per day.

The patient felt well except for easy fatigue until January, 1964, when she noted morning nausea and vomiting and reported that she had not had a menstrual period since November, 1963. A pregnancy test was positive. The blood count (January, 1964) was as follows: hemoglobin 9.6 Gm. per 100 ml., hematocrit 28 per cent, white blood cell count 3,150 cu.mm., platelets 100,000 cu.mm., differential polymorphonuclear leukocytes 40 per cent, lymphocytes 32 per cent, eosinophils 4 per cent, monocytes 24 per cent. Since she had become pregnant while taking 50 mg. of 6 mercaptopurine daily, this medication was continued.

During the next few months, she complained of increasing fatigue and weakness. The platelet count decreased, the white blood cell count increased, and prednisone 30 mg. per day was added to her regimen. The white blood cell count continued to rise, and desacetylmethylcochicine* 4 mg. per day was added during the fifth month of her pregnancy in the hope that it might be useful in controlling the leukemic process. Recurrent anemia required transfusions for correction.

In July, 1964, in the seventh month of pregnancy, the patient developed cramping abdominal pain and was admitted to the Ohio State University Hospital. She was thought to be in early labor, but her pain and uterine contractions subsided 48 hours after admission. Hematologic studies revealed: hemoglobin 11.0 Gm./100 ml., hematocrit 37 per cent, white blood cell count 59,800 cu.mm., platelets 33,000 cu.mm., reticulocytes 0.5 per cent, differential-

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*Colcemid®

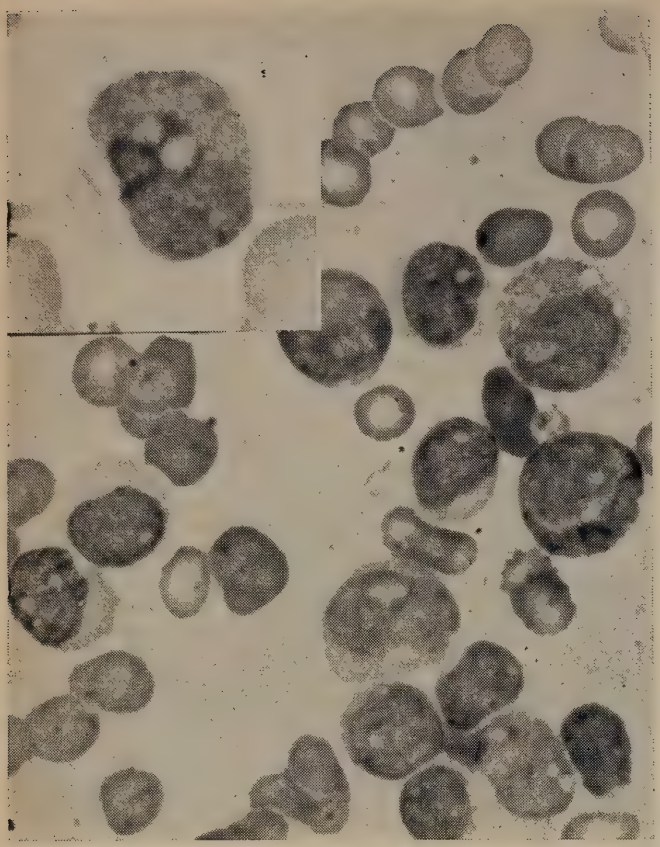


FIG. 1. *Photomicrograph of initial bone marrow smear showing myeloblasts and myelocytes. The insert shows a myeloblast with an Auer body in the cytoplasm.*

myeloblasts 74 per cent, myelocytes 16 per cent. Bone marrow examination revealed replacement of the normal marrow elements by myeloblasts. The fibrinogen level was 0.98 Gm./100 ml. The findings were consistent with progression of leukemia despite drug therapy, and Colcemid®, and 6 mercaptopurine were discontinued. Methyl guanyl hydrazone (methyl GAG) was considered the drug of choice despite its toxicity, since remission had been reported in a significant number of patients with acute myeloid leukemia following the use of this drug.

After the initial infusion of 150 mg. of methyl GAG, the patient went into labor, and six hours later she was delivered of a normal, male infant weighing 1730 Gm. (3 lbs. 13 oz.). The delivery was uneventful, and the child was without evidence of developmental abnormalities. Examination of the placenta showed no remarkable abnormalities. The cord hemoglobin was 18.4 Gm. per 100 ml., and the infant's white blood cells were normal.

After delivery, the patient's oral temperature rose daily to 104°F. There was no obvious source of infection immediately postpartum, but she subsequently developed large furuncles on the scalp. Culture of exudate from the scalp lesions revealed *Pseudomonas Aeruginosa* and *Staphylococcus Aureus,* and she was treated with Colistin and sodium methicillin. Her temperature gradually returned to normal after the initiation of antibiotic therapy, and 150 mg. of methyl GAG was given intravenously daily. A gradual reduction in the white blood count occurred, and a bone marrow examination two weeks after the initiation of treatment with methyl GAG revealed an increased number of mature granulocytes and a decrease in myeloblasts. The patient improved clinically with a gradual return of strength. At the time of discharge from the hospital, the hemoglobin was 12.0 Gm. per 100 ml., hematocrit 39 per cent, white blood cell count 94,000 cu.mm., platelets 29,000 cu.mm, differential polymorphonuclear leukocytes 28 per cent, myelocytes 30 per cent, myeloblasts 32 per cent, lymphocytes 10 per cent.

After discharge from the hospital, the patient was maintained in clinical remission with weekly injections of methyl GAG, but anemia and thrombopenia gradually became more severe. In February, 1965, seven months postpartum, and 18 months after the initial diagnosis of leukemia, she was readmitted to the hospital because of marked weakness and fever. The white blood cell count was 50,000 cu.mm., hemoglobin 9.3 Gm. per 100 ml., hematocrit 31.5 per cent, platelets 21,000 cu.mm., differential-myeloblasts 82 per cent, myelocytes 18 per cent. She died 24 hours after admission to the hospital.

Postmortem examination revealed changes consistent with acute myeloblastic leukemia in relapse. The final anatomic diagnoses were: (1) Acute myelogenous leukemia with leukemic infiltration of esophagus, lungs, gastrointestinal tract, liver, spleen, lymph nodes, and kidneys. (2) Pulmonary edema.

The infant was discharged from the hospital weighing 2175 Gm. (4 lbs. 13 oz.) at the age of one month. He has shown normal growth and development, and at the age of 1 year his weight was 22¼ lbs., length 29¼ inches, and there was no evidence of a developmental abnormality. A complete blood count revealed no abnormalities except a moderate iron deficiency anemia (Hemoglobin 10.8 Gm./100 ml.).

Discussion

The use of antileukemic drugs during the first trimester of pregnancy is considered dangerous, and some authorities recommend the limitation of treatment to symptomatic and supportive care and the administration of corticosteroids.[3,4] In our patient, conception occurred while she was receiving 6 mercaptopurine and was followed by a relatively uneventful pregnancy. The infant was born prematurely but showed no evidence of developmental abnormalities.

This experience is not unique. There are six cases in addition to our own in which 6 mercaptopurine has been given during the first trimester of pregnancy.[1] In these seven cases six infants were born alive, two dying shortly after birth, one was stillborn, and none showed evidence of developmental abnormalities. This experience indicates that 6 mercaptopurine can be given during the first trimester in amounts not exceeding 2.5 mg./kg. of body weight without fear of inducing fetal abnormalities or abortion. We agree with Frankel and Myers that therapy of acute leukemia with 6 mercaptopurine need not be restricted during the first trimester.[5] Indeed, it would seem unwise to withhold therapy since treatment with an effective antileukemic drug affords a reasonable chance for completion of pregnancy and the birth of a normal infant.

There is little information concerning the effect in pregnancy of the other drugs which were used in this case. Desacetylmethylcochicine is a stathmokinetic agent and is not widely used in the treatment of acute leukemia. Lessman and Sokal have reported a patient with chronic myeloid leukemia, who conceived and delivered a normal infant while on continuous treatment with this drug.[6]

Methyl GAG has been reported to produce complete remission in 45 per cent of patients with acute myeloblastic leukemia receiving optimal treatment.[7] The highest response rate has occurred in patients in whom the leukemic cells showed Auer bodies and/or significant granulation as was the case in our patient. Methyl GAG is extremely toxic, and produces mar-

row hypoplasia, mucosal ulcerations, phlebitis, and, in some instances, hypoglycemia.[8] Following the initial infusion of 150 mg. of Methyl GAG, our patient went into labor, which was probably only coincidence but an effect of the drug on the uterus cannot be excluded. At any rate no immediate toxic effects were noted on the infant, and the partial remission obtained postpartum was attributed to this drug.

The side effects of prolonged corticosteroid administration are well known, and fluid retention may be exaggerated during pregnancy. Suppression of the adrenal function of the infant may also occur as a consequence of corticosteroid administration to the mother and should be sought for diligently in the newborn.

Leukocytosis and the presence of immature white blood cells in the peripheral blood are often associated with pregnancy. Kuvin and Brecher found leukocytosis in 20 per cent of normal women in the last trimester of pregnancy and myelocytes or metamyelocytes in the peripheral blood in 25 per cent.[9] Even though there are hematologic changes consistent with increased myelopoiesis, there is no evidence that either acute or chronic leukemia of any type is made worse by pregnancy. The principal adverse effect of pregnancy in acute leukemia is the limitation imposed on the amount and type of antileukemic drug administered. Therapeutic abortion is not indicated and may be more dangerous than continuation of the pregnancy.

The management of this type of patient is difficult, since complications may occur at any time, and delivery is particularly hazardous because of the possibility of hemorrhage and puerperal infection. Thrombocytopenia is the most common cause of abnormal bleeding, but hypofibrinogenemia has also been reported.[10] The use of corticosteroids and platelet transfusions may ameliorate the bleeding due to thrombocytopenia, and replacement therapy should be instituted if fibrinogen is decreased. Delivery was not associated with untoward bleeding in our patient even though the platelets were decreased, but her fibrinogen level was normal.

Rapid deterioration of patients with acute leukemia is common in the immediate postpartum period. The causes of this deterioration are often not immediately apparent, and both exacerbation of the leukemic process and infection may be responsible. The hematologic status of the patient should be carefully followed, because more vigorous treatment of leukemia is often necessary in the postpartum period. Close medical observation is necessary to detect infection, and we feel that antibiotic therapy should be promptly instituted after appropriate bacteriologic studies, if fever develops.

There are several aspects concerning infants born of leukemic mothers that are of interest. Very little information is available regarding delayed toxicity in the infant from the prenatal administration of antileukemic drugs to the mother. There is no evidence of delayed toxicity from 6 mercaptopurine administration, but experience is limited. The possibility of transmission of leukemia from the mother to the infant is of obvious importance. Finch, in a review of the transmission of leukemia, found no evidence of leukemia in infants born to women with leukemia, but Cramblett et al have reported the development of leukemia at 9 months of age in an infant born of a leukemic mother.[11,12] Although there may be no immediate evidence of leukemia in the infant, careful follow-up is necessary to exclude the later development of the disease. For this reason Moloney has urged that all cases of leukemia in pregnancy be reported with follow-up studies on the infant.[1] In our case, the infant showed no evidence of leukemia at 1 year of age and is remarkably normal considering the hazards associated with his intrauterine existence.

Pregnancy is uncommon in patients with acute leukemia but it is apparent that the presence of acute leukemia, and the administration of some types of antileukemic drugs do not prevent pregnancy. A discussion of the philosophic reasons for preventing pregnancy in women with acute leukemia is beyond the scope of the present report, but it may be fairly stated that the development of pregnancy does not simplify the management of leukemia.

Summary

A woman with acute leukemia conceived while receiving the antileukemic drug 6 mercaptopurine. Antileukemic therapy was maintained through the course of pregnancy, and she subsequently delivered a normal, premature infant. It is suggested that pregnancy is not an absolute contraindication to the treatment of acute leukemia with effective antileukemic drugs, eg, 6 mercaptopurine.

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A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

PRESENTATION OF CASE

First Admission: Three and a half years prior to his death this white man, aged 54, was first admitted to Ohio State University Hospital for treatment of a right pleural effusion that had been recurring for two and a half years. Thoracentesis had been performed five or six times, and diuretics had been given intermittently. During this period the patient had also been treated with P^{32} for lymphatic leukemia. The patient denied all cardiopulmonary symptoms except dyspnea on exertion.

On physical examination the vital signs were normal. No lymph nodes were palpable. There was dullness in the lower half of the right chest with associated physical findings of a pleural effusion. The spleen was palpable 6 cm. below the left costal margin and the liver 4 cm. below the right; both organs were tender. The blood pressure was 100/60. The remainder of the physical examination gave normal findings.

The laboratory examinations showed a white blood count of 26,300 with 22 per cent neutrophils, 2 per cent eosinophils, 72 per cent lymphocytes, and 4 per cent monocytes; the hemoglobin was 14 Gm., the red cell count 5.76 mil., the platelet count 530,000, reticulocytes 3 per cent. The fasting blood sugar, the urea nitrogen, uric acid, creatinine, serum electrolytes, alkaline phosphatase, van den Bergh, total protein and albumin/globulin ratio were within normal limits. The chest x-ray showed a right pleural effusion and questionable cardiomegaly.

A thoracentesis yielded 1,800 cc. of clear serous fluid having a specific gravity of 1.015 and containing 540 mg. of protein per 100 ml. Smear of the fluid showed many mature lymphocytes and eosinophils; no growth was obtained on culture. Cytoxan® (500 mg.) was inserted into the right pleural space. The patient was discharged on the second hospital day.

Second Admission

Eight months later the patient was again admitted for thoracentesis since fluid had been accumulating more rapidly in the last month. The physical and laboratory findings were very similar to those of the previous admission except that there was now atrial fibrillation. A right thoracentesis removed 1,600 cc. of serosanguineous fluid that did not clot. Papanicolaou smear of the fluid was reported as Class III with the specimen consisting almost entirely of red blood cells and mature lymphocytes with an occasional atypical lymphocyte. Cytoxan (1,000 mg.) was injected into the pleural cavity. The patient was discharged on treatment with HydroDIURIL® (50 mg. twice daily) and a low salt diet, to be followed by his family physician.

Third Admission

After five months the patient was readmitted with massive ascites but otherwise in much the same state. On chest x-ray the heart had normal size and contour, but the heart sounds were distant and one observer heard a friction rub. Fibrocalcific infiltrations were seen in both hilar areas, resulting in enlargement of the right hilum. There were changes compatible with right fibrothorax and loculated pleural effusion on the right side. Two paracenteses were performed and a total of 4,500 cc. of fluid was obtained; 1,000 mg. of Cytoxan was injected intraperitoneally without incident. The patient was discharged on the third hospital day to continue treatment on HydroDIURIL (70 mg. twice daily) and digitalis.

Fourth Admission

In the following five months the patient's ascites became increasingly difficult to manage medically and he was readmitted for paracentesis. He had had increasing dyspnea on exertion and paroxysmal noc-

Presented by

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turnal dyspnea. There was massive ascites, and the neck veins filled from below. Pleural friction rubs were heard at the left base posteriorly. The electrocardiogram showed atrial fibrillation, low voltage, incomplete left bundle branch block, and nonspecific myocardial changes. The blood pressure was 100/70. At paracentesis, 4,000 cc. of fluid was removed and 1,000 mg. of Cytoxan was instilled into the peritoneal cavity. He was discharged on the second hospital day with instructions to take a thiazide diuretic (500 mg. per day), digitoxin, and a low salt diet.

Final Admission

During the next two years the patient underwent 18 combined thoracenteses and paracenteses. He had been taking digitoxin and diuretics daily. His final admission was for treatment of his chronically recurring pleural effusion and ascites.

His blood pressure was 105/90, pulse rate 120 per minute and irregular, respirations 20 per min., temperature 96°. The patient had obvious anasarca. There were erythematous eruptions on his abdomen. The pupils were miotic and funduscopic examination was not possible. The neck showed venous engorgement at 90°. There was no lymphadenopathy. The respiratory movements on the right were decreased, with dullness and decreased breath sounds. The left side had wet rales throughout the lung fields. The heart had the rhythm of atrial fibrillation, was not enlarged to percussion; the heart sounds were distant and no murmurs were described. The radial pulses were decreased bilaterally; the veins of the upper extremities were markedly engorged. There was marked ascites. The liver was palpable 4 cm. below the right costal margin; the spleen was not palpable. The scrotum and lower extremities showed marked edema.

The white blood cell count was 11,700 with 50 per cent neutrophils, 4 per cent eosinophils, 30 per cent lymphocytes, and 12 per cent monocytes; red blood count 4.9 mil., reticulocytes 3 per cent, platelets 860,000; hemoglobin 15.5 Gm. The urine had a specific gravity of 1.018, a pH of 6, and contained many epithelial cells. The uric acid was 7.8 mg., creatinine 2.5 mg., fasting blood sugar 96 mg./100 ml. The alkaline phosphatase was 7.7 units; inorganic phosphorus 6.7 mg./100 ml.; total protein 6.9 Gm./100 ml. with 3.6 Gm. of albumin and 3.3 Gm. of globulin. The van den Bergh was normal, and the prothrombin time was 42 per cent of normal. The serum sodium was 137, the potassium 4.8, chloride 92, and CO_2 combining power 34 mEq./liter. The chest x-ray showed bilateral pleural effusions and an air-fluid level on the right side. A patchy infiltrate was described in the area of the lingula.

The patient, in critical condition upon admission, deteriorated rapidly. In an attempt to relieve his dyspnea, a thoracentesis was performed and 1,000 cc. of yellow-pink, turbid, lymph-like fluid was removed from his right chest. He was treated with digitalis, Aldactone®, Mercuhydrin®, and 100 cc. of albumin in an attempt to produce diuresis. Terminally, it was believed that he was in pulmonary edema. Phlebotomy was unsuccessful, and he died quietly on the second hospital day.

CLINICAL DISCUSSION

DR. WALL: This was a man in his sixth decade who early in that decade developed a right pleural effusion. Although we don't have the details of his outpatient history, he apparently was found to have chronic lymphatic leukemia and was given radioactive phosphorus. I think there is little doubt throughout his course that he had chronic lymphatic leukemia. However, this seemed to be fairly easily controlled in most of its aspects, and at the time of the man's death his chronic lymphatic leukemia was still relatively mild as it relates to his blood. It might not be relatively mild as it relates to tissue infiltrates, but I would wonder if his chronic lymphatic leukemia actually had much to do with his death.

At his first admission, the problem was one of pleural fluid that recurred, unilateral on the right, for which he had been tapped a number of times before he was seen. It is important, I think, that at that time, if this is a true observation, he had a normal sinus rhythm to his heart and there was only very questionable cardiomegaly on x-ray. His pleural effusion did show a fairly significant population of lymphocytes and, while this is not diagnostic, many times the pleural effusions related to leukemia can have some extra lymphocytes in them, surely in chronic lymphatic leukemia patients. If we would believe, as the clinical people did at that time, that this was probably related to his primary disease, then their use of intrapleural alkylating agents is valid and it will reduce the pleural effusion. Most frequently it will reduce it in relationship to obliteration of the pleural space rather than actually being too effective at lymphatic blockage.

Apparently this helped him to some degree. Eight months later, however, he was readmitted and this time he had different problems, namely, those of ascites and edema which apparently weren't present before, and at this time he had atrial fibrillation but again without any significant cardiomegaly. The electrocardiogram at that time apparently showed some low voltage and myocardial changes, but in the absence of cardiomegaly, which seems to be important throughout his entire observation period. No additional information regarding venous pressure distributions, neck veins and things like that, is present at this time. So we now know that where he had a long-standing recurrent right pleural effusion he now had significant ascites and edema. On subsequent readmissions to the hospital the ascites and peripheral

edema became more marked and persisted for the remaining few years until his death.

It is important, I think, that when for the first time his blood pressure was reported, it was 100/60, and at no time did he show any significant wide pulse pressure or hypertension. His pulse rate at many times was quite low, but most of the time it was above 100 to 120, in the absence of anemia related to his chronic lymphatic leukemia. On the third admission one observer heard a friction rub over his cardiac area, and his heart sounds were distant and remained distant until his death. No murmurs are described until late in the course of his disease. At this time they did note that his neck veins were significantly distended.

Again in another five months, or about two years before his death, he was readmitted and at this time there was no significant cardiomegaly, and the man again had ascites and dependent edema. Now he had developed paroxysmal nocturnal dyspnea, which is a newly described event, and his effusions at this time were bilateral. They were also thought to be accompanied by a pleural effusion rub at this time, distinct from his previous friction rub which was thought to be pericardial. His edema was much more massive at this time and extended to his thighs. Again his blood pressure showed very narrow pulse pressure; it was only 30 mm. His neck veins were markedly distended in upright sitting position. His electrocardiogram showed a low voltage and now an incomplete left bundle branch block and myocardial changes, probably ST segment and T wave changes. So the man does seem to have had progressive myocardial disease, but his myocardial disease never tended toward cardiomegaly at any time, which probably is significant.

Then we didn't hear from him for two years, until he came in for only a 24-hour stay before he died. During that two-year interval he had had 18 thoroparacenteses. On admission again his blood pressure was low with a very narrow pulse pressure of only 15 mm. of mercury, a pulse of only 120 in a man with generalized anasarca, no cardiomegaly, no murmurs, and distant heart sounds.

No Question About Leukemia

In reconstructing his history, I think this man had chronic lymphatic leukemia, even though we don't have any description of bone marrow examination at any time. I'm sure it was done or radioactive phosphorus wouldn't have been used. It was mild, because at the time of his death he still did not have any significant anemia, thrombocytopenia, or any of the sequelae that we see in the patient with progressive chronic lymphatic leukemia whose course is one of gradual deterioration and death.

Could his pleural effusions originally have been related to his chronic lymphatic leukemia? Surely; it's not an uncommon event, although it is an uncommon event in easily controlled chronic lymphatic leukemia patients. Would there be other reasons to develop isolated pleural effusions without other fluid collections as he did, which actually preceded significantly his ascites and edema? Surely; these people can get node and lymphatic infiltration with localized obstruction. It's unusual to stay that way that long, but again this man was influenced by repeated intrapleural therapy using Cytoxan, and this could have influenced the rate of recurrence. Could it all have been cardiac in origin? It's possible, but it kept recurring for two and a half years before he got any ascites, in the absence of cardiomegaly and with fairly respectable cardiac function up until that time.

Constrictive Pericarditis?

In a person who shows massive ascites, hepatomegaly at times unassociated with splenomegaly, peripheral massive edema, and with a long chronic course, one must think of constrictive pericarditis. We never had any description of significant calcification of the pericardium on any of his x-rays, but there are limitations in reading those in a person with recurrent pleural effusion. Could he have constrictive pericarditis? There is a good possibility, I think, in a man with a significantly lowered systolic pressure, a normal pressure, a very narrow pulse pressure, marked venous neck distention, no murmurs, a low voltage as his myocardium gradually deteriorates, no auricular fibrillation to begin with and later auricular fibrillation, which I understand is not too uncommon in constrictive pericarditis. A pericardial friction rub, which we cannot ignore, was described at least by one observer, and in the face of all of the measures one usually uses in congestive failure — such as sodium restriction, diuresis, digitalis — he didn't show any significant improvement. This is also a little characteristic of constrictive pericarditis.

Could he have nonconstrictive pericarditis? Could he have mediastinal pericarditis? adhesive pericarditis? which is surely uncommon. Could he have an immobile heart sitting in the middle here? I think he could. Could he have a tricuspid stenosis? He could, but there is very little evidence to support it — the lack of murmurs, the lack of significant cardiomegaly as his disease progresses. Not many things support that diagnosis.

I don't know which of these is true, but I think from the evidence available I would undoubtedly go with chronic lymphatic leukemia, possibly with a pleural effusion originally occurring related to that disease, and with subsequent constrictive pericarditis over a period of some time. If this is true, then it would indeed be tragic, because there is always the possibility that this is amenable to surgical correction. As for the specific etiologic agent, I would first suggest, for reasons of frequency, a tuberculous

origin, but there is very little evidence to support this. Maybe we could see the electrocardiograms and x-rays.

DR. FREIMANIS: The first film that I have, shows indeed a considerable effusion; it is mainly on the right side — in fact, at that time we could not identify any fluid on the left side at all. However, there is a quite massive right-sided pleural effusion. The size of the heart cannot be measured accurately because the pleural effusion extended down and lies next to the right heart border. However, it is worth noticing that the heart does not protrude particularly far to the left and the left lung is not particularly congested.

About a year after the original film, the fluid in the right side is increased somewhat more, and a year later he came back with the same thing. So there is the continuous presence of pleural fluid on the right side which was gradually increasing in spite of the fact that it was being removed and treated otherwise, without any really good demonstration of underlying primary pulmonary disease either on the right or left side. The heart always remained small, even in the rather late stages of the disease. A pyelogram showed normal kidneys. An upper G. I. series showed an intrinsically normal esophagus, stomach and duodenum.

Terminally, the patient still shows a massive right-sided pleural effusion. Now he also has a left-sided pleural effusion which is quite massive. There is pulmonary edema and a lingular infiltration was described. This may be an area of pneumonitis, it may be just some more pulmonary edema. At this point he was in heart failure and yet remarkably enough the heart still remained *probably* about the same size. He had pulmonary edema, bilateral pleural effusion, and again ascites and enlargement of the liver and spleen. As far as calcifications in the heart are concerned, I cannot see any. This of course does not exclude constrictive pericarditis.

DR. RYAN: The E. K. G. is not of much more help than the x-rays. It just shows atrial fibrillation. Notice there are no P-waves. Look at the sharp reduction of the voltages of all the QRS complexes, which is consistent with pericardial effusion; it is consistent with any gross accumulation of fluid. The T-waves are inverted, very nonspecific, and may very well be due to digitalis.

CLINICAL DIAGNOSIS

1. Chronic lymphatic leukemia.
2. Persistent pleural effusion.
3. Constrictive pericarditis.

PATHOLOGIC DIAGNOSIS

1. Chronic lymphatic leukemia.
2. Constrictive pericarditis.
3. Mediastinal fibrosis.
4. Chylous ascites and pleural effusion.
5. Tracheal diverticulum.

DISCUSSION OF PATHOLOGY

DR. MACPHERSON: The diagnosis really could be made essentially on the gross features at autopsy. This picture shows a very markedly distended upper mediastinal vein that did not collapse and was in keeping with the remark in the protocol that they "filled from below." This was the first point that was striking at the autopsy. The next picture shows the abdominal cavity, and the striking feature here is this chylous material; there were 6,000 cc. in the peritoneal cavity. This fluid was sterile on culture, and the purulent appearance is due entirely to the presence of fat droplets. There was thickening of the mesentery, and this was actually a very chronic process; there is fibrosis, thickening of the wall, and the bowel is matted together. This appearance, I believe, is secondary to chemical irritation.

There is marked thickening of the capsule of the liver; it is patchy and there were marked adhesions around. The spleen is even more grossly involved than the liver was — the so-called sugar-icing spleen. All of the organs in the peritoneal cavity showed marked thickening of the capsule, and the chylous fluid was also present in the chest.

Here we have the pericardial sac, and you see here adherence of the heart to the pericardium. There was no pericardial effusion. There was marked thickening of the parietal pericardium where it came in contact with the pleura and mediastinum. This was continuous with the thickening of the under surface of the diaphragm and of the peritoneum over that area. So what we had essentially was a tremendously matted, thickened, fibrotic pericardium, pleura, and mediastinum. There were pleural effusions on both sides, a small one on the right and a larger one (about 500 cc.) on the left, and in addition the left lung only showed considerable edema. The right lung was atelectatic and was quite contracted down and covered with a thick capsule. There was calcium in the parietal layer of the pericardium; it was patchy and was present in sort of flat plaques and was not uniform at all.

When we opened up the trachea, there was a very interesting observation, namely, a small fistula in the trachea just at the bifurcation. It was found to communicate with a typical chronic, caseous lymph node. This was the only evidence of tuberculosis anywhere in the body. It is certainly very unusual to find this in the absence of active disease elsewhere.

Histologically, there is an infiltrate of lymphocytes in the bone marrow, which was essentially normal throughout but showed small patches of lymphocytes here and there. This was interpreted as being evidence of chronic lymphatic leukemia because virtually every organ examined showed the infiltrates of chronic

lymphatic leukemia. The mediastinal lymph nodes were not grossly enlarged but they all showed disorganization of their structure and infiltration out through the capsule of the node. The pleura showed a thick layer of fibrous tissue on the surface and beneath that extensive infiltrates due to chronic lymphatic leukemia. The same thing was seen to a much lesser degree in the pericardium. It was also seen in the spleen and in the intestinal tract. So, even though the lymphatic leukemia was obviously quite quiescent clinically and did not show much evidence in the blood, it was very widespread throughout the body but nowhere did it show evidence of great activity. The cells were primarily mature lymphocytes; there were few mitotic figures; there were few primitive cells.

We must first explain the congestive heart failure. There was no evidence of any valvular disease or any significant disease of the coronary arteries; there was no fibrosis nor infiltrate of the myocardium. There was extensive constrictive pericarditis which was linked up to the fibrosis of the pleura and of the mediastinum. There was also virtual absence and nonfunction of the right lung. We felt that this was constrictive pericarditis but we were not really able to decide whether it was primarily a tuberculous pericarditis, complicated by the other events that followed it, or whether it was primarily a Cytoxan-induced pericarditis with the extensive fibrosis which was also seen in the pleura and in the mediastinum. As to the chylous ascites, this is quite clearly due to obstruction of the thoracic duct by the massive fibrosis in the mediastinum and elsewhere. This would be one point in favor of saying that the pericarditis was probably related to the Cytoxan therapy, but I don't think that we can exclude the possibility of a tuberculous etiology complicated by the treatment of the lymphatic leukemia.

General Discussion

DR. RYAN: Usually as you approach constrictive pericarditis, this is a very difficult plane for the surgeon to identify. I do know that we used to say that there were localized constrictions and then this became unfashionable — that the whole heart had to be involved. Now we are beginning to accept evidences of localized constrictions, if they are in the right place (as in the sulcus between the atria and ventricles), that mimic valve defects. This certainly didn't look like the usual constrictive pericarditis; it looked like a pretty free space.

DR. MACPHERSON: I think the space was not as free as it appeared in that picture because there had been extensive dissection before they could get it loosened up to that degree. But there was not the uniform and massive fibrosis that one normally associates with this entity. On the other hand, the points that we felt were in favor of constrictive pericarditis were the degree of fibrosis of the parietal pericardium with calcification, and secondly, the fact that the heart was not markedly dilated at all.

DR. RYAN: Dr. Wall, do you have any comments?

DR. WALL: No. We still put these substances in the pleural space. We have been more impressed in recent years that maybe we need to get surgical assistance when we get a man like this with recurrent effusions: have a surgeon split an intercostal space and put in a mushroom catheter, suck out the area, and plaster the visceral and parietal pleura against each other and obliterate the space that way and maybe do less damage in the long run.

Heart Failure in Constrictive Pericarditis

DR. RUPPERT: When we speak of constrictive pericarditis we are speaking of right heart failure?

DR. RYAN: You are speaking of whole heart failure.

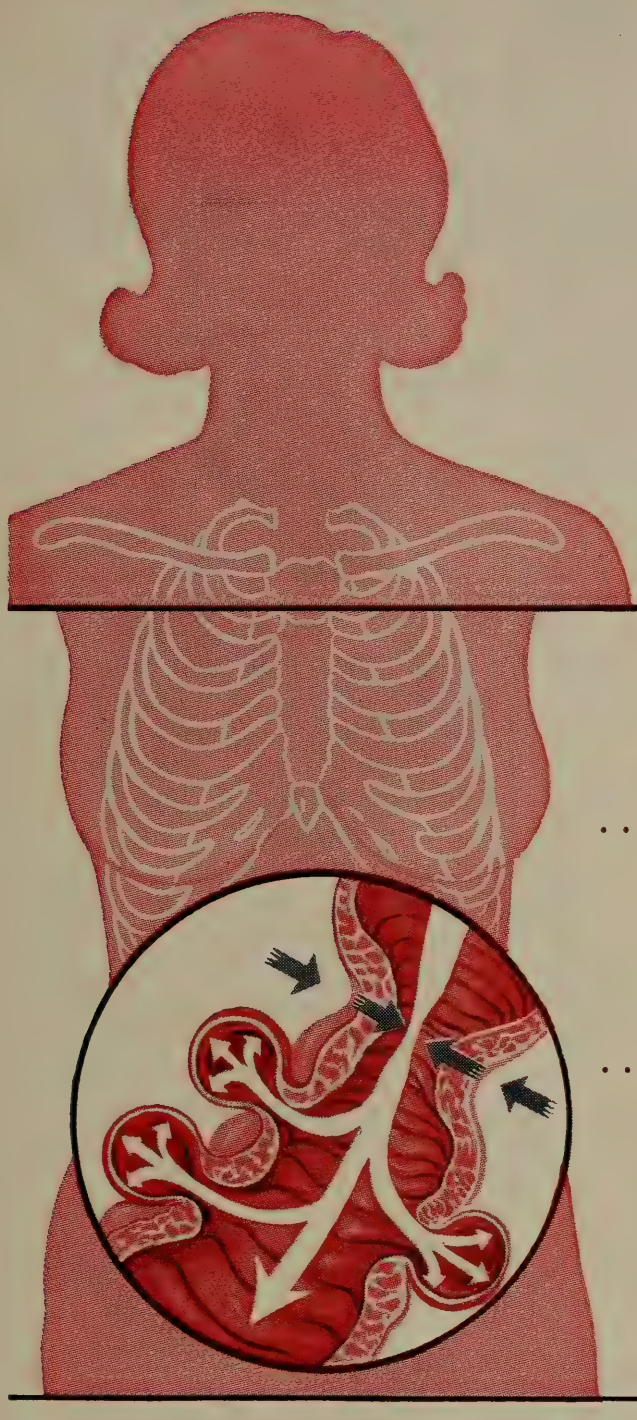
DR. RUPPERT: This goes back to the question: When we see classic constrictive pericarditis, do we see pulmonary edema? Do we see pleural effusion?

DR. RYAN: Yes. You do not have the usual symptomatology of acute pulmonary congestion, but if you make pressure measurements you will find that the pulmonary venous pressure is elevated, the pulmonary artery diastolic pressure is elevated, the right ventricular end-diastolic pressure is elevated, the right atrial pressure is elevated, and the right atrial pressure, the right ventricular end-diastolic pressure, the pulmonary artery end-diastolic pressure, and the pulmonary venous pressure all achieve about the same level, about 20 to 25 mm. The problem is that this disease progresses equally on both sides of the heart apparently, unlike the usual hypertensive, whose left side gives way, or the aortic valve disease, whose left side also gives way.

DR. BROWNING: The original pleural effusion was clear fluid. Apparently it was not chyle at that time. Also 1.015 specific gravity with only a half gram of protein suggests more a transudate than an exudate, doesn't it? I wonder if that is consistent with the leukemic fluid.

DR. WALL: In lymphosarcoma, most patients have transudates, not exudates.

DR. MACPHERSON: We felt that the time interval between the instillation of the Cytoxan into the pleural cavity and the development of fluid in the abdominal cavity would be consistent with fibrosis leading to a chylous ascites as a late complication. We didn't think that it had been there all the time.



Metamucil

. . . to counteract the constipation which is etiologically important and

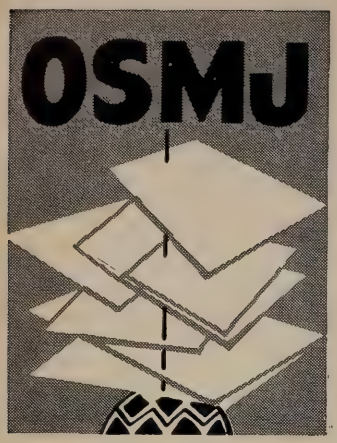
. . . to protect the mucosal surface against physical irritants.

Average Adult Dosage:

One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

SEARLE

Research in the Service of Medicine



NEWS AND Organization Section

New Public Health Regulations On PKU Testing in Ohio

SECTION 3701.501 of the Revised Code of Ohio requiring phenylketonuria tests for all newborn infants, went into effect July 1, 1966. Regulation HE-45-01, implementing that section, was approved by the Public Health Council on June 11.

Information in regard to the law and regulations are presented herewith in three documents issued by the Ohio Department of Health and released to *The Journal* by Dr. E. W. Arnold, director of health. Following are (1) the new regulation approved by the Ohio Health Council, (2) an information sheet concerning the screening program, and (3) supplementary material entitled "Guthrie Inhibition Assay Screening," containing among other data the names of consultants in the field.

STATE OF OHIO
DEPARTMENT OF HEALTH
PUBLIC HEALTH COUNCIL

TESTING FOR PHENYLKETONURIA
CHAPTER HE-45

Authority: Section 3701.501 of the Revised Code

Regulation HE-45-01 — Phenylketonuria test on newborn infants.

HE-45-01. **Phenylketonuria test on newborn infants.**

(A) The Ohio department of health laboratory shall provide, without charge, screening and quantitative tests for phenylketonuria, and specimen collection outfits for tests to be performed in the department's laboratory. The result of each test performed by the said laboratory shall be transmitted in writing to the person who submitted the specimen or to the hospital. In addition, any elevated phenylalanine blood levels six mg. per hundred ml. or above shall be reported to such person immediately by telephone or telegram. In the event the result of a test performed by the said laboratory is a phenylalanine blood level four mg. per hundred ml. or above, the person who submitted the specimen shall cause to be submitted a second specimen to said laboratory as requested in the department's report to such person.

(B) If any laboratory other than the department's laboratory desires to perform tests for phenylketonuria, as required by section 3701.501 of the Revised Code and this regulation, such laboratory must first apply to and receive approval from the director of health and shall:

(1) Use either the Guthrie Inhibition Assay blood screening test or a quantitative fluorometric procedure approved by the director; provided, other tests may be permitted if prior written application has been made and approval given by the director;

(2) Use filter paper disc controls with each Guthrie plate, and serum controls of known reactivity for the fluorometric procedure;

(3) Complete each test within three working days after receiving the specimen and promptly transmit the results of each test performed to the person who submitted the specimen on forms prescribed and provided by the director;

(4) In addition to complying with subdivision (B) (3) of this regulation, report by telephone or telegram to the person who submitted the specimen any elevated phenylalanine blood levels of six mg. per hundred ml. or above;

(5) Request the person who submitted a specimen which had a test result of a phenylalanine blood level four mg. per hundred ml. or above to submit a second specimen to the department of health laboratory, or to another laboratory approved by the director under this regulation;

(6) Report monthly to the department of

health the total number of infants tested and the total number of tests performed, and immediately report to the department the names of infants showing elevated levels of phenylalanine above six mg. per hundred ml. and the name and address of the person submitting the specimen. These reports must be substantiated by records which shall be kept in the laboratory for not less than two years;

(7) Accept and test unknown specimens from the department of health, and report results of testing such specimens to the department within two weeks.

(C) The person required to file a certificate of birth under section 3705.14 of the Revised Code shall cause specimens to be collected as follows:

(1) The attending physician shall cause a blood specimen to be collected from each newborn child which shall be not sooner than 24 hours after the first protein feeding, and a specimen collected from an infant receiving antibiotics parenterally or orally shall be so labeled; provided, a blood specimen shall be collected from a premature infant when the attending physician determines that such specimen collection is no longer contraindicated;

(2) Where a birth does not occur in a hospital, the attending physician or midwife shall cause a blood specimen to be collected for testing for phenylketonuria. Such specimen shall be collected within the first two weeks of life, but not sooner than 24 hours after the first protein feeding;

(3) If there is no physician or midwife in attendance at the time of birth, the local registrar of vital statistics, when notified that such a birth has occurred, shall report the occurrence of the birth to the health commissioner of the health district in which the birth occurred. The health commissioner shall cause a blood specimen to be collected for testing for phenylketonuria within seven days after being notified of the birth of a newborn child, but not sooner than 24 hours after the first protein feeding;

(4) A specimen shall be sent to the laboratory not later than 48 hours after it is collected;

(5) A repeat specimen shall be collected within 72 hours if the first is inadequate or unsatisfactory.

(Adopted June 11, 1966; effective July 1, 1966.)

PHENYLKETONURIA

Information for Hospitals and Physicians

Screening of Newborn Infants for Phenylketonuria

Ohio Department of Health
Bureau of Laboratories

The Ohio Department of Health Laboratory will provide, without charge, screening and quantitative tests for phenylketonuria, and specimen collection outfits for tests to be performed in the department's laboratory upon the request of the hospital administrator.

I. SUPPLIES

The department of health laboratory provides the hospital with specimen collection kits which consist of (1) a special four-part, numbered filter paper collection form, with instructions for collection of the specimen, (2) a disposable, sterile lancet and (3) a preaddressed envelope for mailing the specimens to the Ohio Department of Health Laboratory. These kits will be provided to the hospital at approximate six-month intervals. The quantity will be determined by the number of births anticipated. Extra un-numbered filters can be obtained by private physicians upon request.

II. IDENTIFICATION

All information requested on the filter paper collection form must be provided. This information should be **clearly** printed with a ball point pen. Label specimens collected from infants using antibiotics.

III. SPECIMENS

A. Method of Collection

Note on infant's record the fact that the specimen has been taken: hold record in record room pending laboratory results. Collect the blood specimen from a heel puncture using a sterile disposable lancet. Apply pressure to the heel, allowing a large drop to form. Blot it off on the filter paper so that one drop **fills** each of the three printed circles and soaks **through** the paper. The appearance of the blood spot should be similar on both sides of the paper. Two full drops are better than three tiny drops. Repeated dabbing of tiny drops will not give an adequate specimen. Specimens not adequate for testing will be returned to the sender.

B. Time of Collection

The blood specimen for testing should be obtained no sooner than 24 hours after the first protein feeding except:

"(A) An infant receiving only breast milk should have the specimen taken during the fourth to the tenth day of life.

"(b) An infant of less than 4½ pounds birth weight should have the specimen taken during the seventh to 14th day of life.

"(c) An infant from whom a specimen cannot be obtained in the hospital within these criteria (for example, discharged from the hospital too soon, born outside the hospital) should have the specimen taken within the first two weeks of life."

IV. STORAGE

After the filter paper specimens have been air-

dried, they should be placed in the small transparent envelope and stored in the larger mailing envelopes.

V. MAILING

Specimens are to be mailed to the laboratory twice weekly. Specimens should never be kept for more than four days. Early detection of PKU is of prime importance.

VI. REPORTING OF TEST RESULTS

Two copies of each test result are sent to the hospital, one for the hospital record and one to be transmitted by the hospital to the physician.

Results of tests are reported in three categories:

A. "Less than 4 mg. per hundred ml."

A "less than 4 mg./100 ml." result indicates a negative test or a "normal" blood phenylalanine level.

B. Unsatisfactory specimen

This report is returned to the sender when there is an insufficient blood sample or diluted blood on the filter paper. A repeated specimen is necessary in these instances.

C. 4 mg./100 ml. or Over

A level of 4 mg./100 ml. or higher should be considered a "presumptive positive" test. This result is **not diagnostic of phenylketonuria.** A confirmatory test should be performed.

The physician is contacted by letter when a specimen shows a result of 4 mg./100 ml. blood phenylalanine.

(a) A second blood filter paper specimen is requested from the infant.

(b) A blood filter paper specimen is also requested from the mother to check for "Maternal PKU."

The physician is contacted by telephone when a specimen shows a result of 6 mg./100 ml. or higher blood phenylalanine.

(a) One filter paper will be sent for collection of infant's urine.

(b) One blood filter paper specimen is also requested from the mother to check for "Maternal PKU."

(c) A blood collection kit containing microhematocrit tubes. These hematocrit tubes are to be filled, two-thirds full, with whole blood, sealed and mailed to the laboratory for a quantitative analysis.

The importance of obtaining and mailing these blood specimens to the Ohio Department of Health Laboratory promptly cannot be emphasized enough.

VII. DIAGNOSIS AND TREATMENT

If the "special" repeat specimen is still above the normal range, the physician is urged to take immediate steps to obtain consultation. (See names and addresses of consultants beginning on page 825.)

It is imperative not to start treatment until a child has been properly diagnosed as phenylketonuric. Treatment with a low phenylalanine diet requires close attention to nutritional needs and is reserved only for the confirmed case of PKU. Physicians treating confirmed cases of PKU may request Lofenalac® from the Division of Maternal and Child Health for their patients whose families cannot afford the cost of the special diet. Consultation regarding nutrition management of a child with PKU is available from nutritionists on state or local health department staffs.

GUTHRIE INHIBITION ASSAY SCREENING FACTORS TO CONSIDER

Initial Testing

1. The infant on breast feeding **may** not have an adequate protein intake within 24 hours after the start of breast feeding. Consideration should be given to testing these infants at the end of their hospital stay. If they are discharged from the hospital under three days it is **imperative** to retest in the physician's office on the first return visit.

(Michigan regulations state "an infant receiving only breast milk shall be tested during the fourth to tenth day of life.")

(Additional test filters will be supplied to the private physician on request.)

2. Infants on antibiotics should have the filter paper marked "antibiotics." Tests thus marked will be performed by other methods. Because the Guthrie relies on bacterial action, the presence of antibiotics can be recognized **after** the test is completed, thus requiring retesting and the delay in reporting.

3. Physicians may wish to enlist the aid of their local City or County Health Department to locate infants discharged prior to their being on formula for 24 hours. Arrangements can be made for the physician to request the public health nurse to take the sample specimen in the home. This would also provide a continuity of health care that many of these people would not otherwise receive.

Prematurity

1. Many premature infants will show an elevation of phenylalanine. Retesting should continue until levels return to normal or a diagnosis of PKU or other condition is made. Frequency of retesting should be determined by the physician giving due consideration to the degree of prematurity and levels of phenylalanine found.

2. When phenylalanine levels are elevated it is desirable to use quantitative testing including examination of the tyrosine and other amino acids.

In a recent study of premature infants born at Cincinnati General Hospital, 25 per cent of premature infants **not** given supplemental doses of ascorbic

acid developed elevation of tyrosine and phenylalanine in the blood and excreted large amounts of tyrosine and tyrosine derivatives. Tyrosine levels may range from 10 to 75 mg./100 ml. — usually excluding the diagnosis of PKU.

3. These infants should be followed until levels become normal.

Some Known Reasons for Phenylalanine Elevations on the Guthrie Screening other Than PKU. (Sometimes Termed Phenylalaninemia or Hyperphenylalaninemia)

1. High protein feeding: A surprising number of full term infants apparently are unable to metabolize proteins completely in early infancy. Changing the formula to one with a lower protein content will sometimes return the level to the normal range. (See listing of protein values of some common infant feedings, on this page.

2. Some infants with an elevation of both phenylalanine and tyrosine require the addition of 100 mg. of vitamin C daily to return both levels to the normal range. (Some infants require additional folic acid.)

3. The repeat test following a trial of lower protein formula and additional vitamin C should be a fasting specimen.

4. If the phenylalanine levels remain elevated (in the absence of the keto acids and their derivatives) the possibility of a carrier state should be considered. Exploration of family antecedents may reveal a history of mental retardation. Because PKU follows an autosomal recessive inheritance pattern, it would be most unusual to find other immediate family members (besides siblings) with the disease. In the pedigree there is a greater likelihood of consanguinity than found in the general population; however, PKU may show up by mutation or by accidental union of two people who happen to carry the same recessive gene.

5. The possibility of atypical PKU or other disease entities should be explored.

6. Elevations in the levels of tyrosine and phenylalanine have been observed in infants with **untreated** galactosemia, tyrosinosis and liver disease of all types, particularly those that are inflammatory. Jaundice may or may not be present. (Vitamin C has no effect.)

7. A small number of infants have unexplained laboratory findings and should be watched carefully and tested frequently.

Establishing a Diagnosis

The Guthrie Inhibition Assay is a **screening test** only.

The diagnosis of PKU can be made **only** with quantitative testing.

Suggested criteria for establishing a diagnosis include:

Listing of Protein Values of Some Common Infant Feedings

Some Common Infant Feedings	*Protein Content (normal dilution) Grams per 100 ml.*
Human Milk	1.1
SMA® S-26®	1.5
PM 60/40-Similac®	1.5
Enfamil®	1.5
Bremil®	1.5
Similac-20®	1.7
Soyalac®	2.05-2.85
Modilac*	2.15
Nutramigen®	2.2
Bakers-Modified Milk	2.2
Carnalac*	2.28
Veramel*	2.5
Lactum*	2.7
Meat Base Formula	2.85
Mull-Soy®	3.1
Sobee®	3.2
Cow's Milk-Powdered	3.2
Cow's Milk-Undiluted	3.3
Olac®	3.4
Skim Milk	3.4
Evaporated Milk	3.6
Alacta*	3.6
Protein Milk	3.8
Probana®	3.9
Dryco*	4.0
Hi-Pro*	4.6

From Nelson, Waldo E., *Textbook of Pediatrics,* Eighth Edition, 1964

* Trade name products

1. Fasting phenylalanine level over 15 mg./100 ml. by a quantitative method.
2. Tyrosine less than 5 mg./100 ml.
3. Leucine and valine within normal limits.
4. Urine phenylalanine over 100 mg./100 ml.
5. Urine orthohydroxyphenylacetic acid present.

It must be remembered that the presence of phenylpyruvic acid in the urine (which is easily tested for) may be delayed as late as six weeks or even three months.

Phenylalanine and orthohydroxyphenylacetic acid may be present in the urine as early as one to two weeks of age. There is danger of severe growth retardation and mental retardation from "over treatment." Death may also occur from "over treatment." Great harm may be done by treating suspected cases without a firm diagnosis and without adequate monitoring.

It is strongly suggested that the physician seek consultation to determine explanation of the biochemical findings.

The following resource physicians are among those who will provide consultation and follow the PKU aspects of children on request of the private physician:

Thomas M. Teree, M. D., Babies and Childrens Hospital, University Hospital of Cleveland, University Circle, Cleveland, Ohio 44106; Phone: 791-7300, Ext. 2811.

Derrick Lonsdale, M. D., Cleveland Clinic, 2020

(Continued on Next Page)

East 93rd Street, Cleveland, Ohio 44106; Phone: 231-6800, Ext. 601.

Kathryn Huxtable, M. D., Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio; Phone: 351-4820.

Antoinette Eaton, M. D., Children's Hospital, 561 S. 17th Street, Columbus, Ohio 43205.

Betty Sutherland, M. D., Children's Hospital Research Foundation, 240 Bethesda, Cincinnati, Ohio 45229; Phone: 281-6161.

State Services for Crippled Children will pay for the diagnostic metabolic evaluation at one of the centers **if the physician requests this service.**

Follow-Up Treatment

1. Because of the difficulties inherent in administering the low phenylalanine diet, physicians are urged to carry out treatment in consultation with one of the treatment centers. [Emphasis on this point urged by Health Department personnel.]

2. Treatment requires the services of the physician, the nutritionist, the laboratotry, and home follow-up. When possible it is advisable to have social work and psychology services available.

3. Some physicians prefer to follow these children and sometimes need assistance — the Ohio Department of Health offers the following services:

A. Consultation Service: Upon the request of the local physician the state consultants in Nutrition and Nursing in Mental Retardation provide a consultant service which includes:

1. A meeting with the local physician so that there can be a clear understanding and working relationship with the physician.

2. A home visit to the family to further explain the diet and care of the infant. (It is preferred that the local public health nurse be included so that she can coordinate this service with the private physician.)

B. Information Service: Information, pamphlets, leaflets, films, etc., on phenylketonuria and dietary management (recipes) are available to the physician, local health departments, hospitals, etc., (to families on the request of the physician.)

C. Services provided by the Division of Public Health Laboratories:

1. Repeat blood specimen spotted on filter paper is tested on infants whose initial PKU Blood Test or four-weeks PKU Blood Test show 4-6 mg./100 ml. phenylalanine.

a. This repeat specimen is tested by the Guthrie Inhibition Assay Method.

b. The repeat test is negative if it shows less than 4 mg./100 ml. phenylalanine.

c. If the result of the repeat test is 4 mg./100 ml. phenylalanine or higher, the confirmatory test procedure is initiated.

2. Quantitative serum phenylalanine tests using the paper chromatograph technique are run as a confirmatory test of blood screening determinations which show 6 mg./100 ml. phenylalanine or higher. (Tyrosine and other amino acids are also scrutinized.)

As previously stated, the physician is urgently requested to seek assistance from centers when questions arise. If the physician prefers that the state laboratory do additional testing, these services are provided:

a. Quantitative serum phenylalanine determinations run at monthly intervals are suggested if the original serum phenylalanine test shows results of 4-10 mg./100 ml. phenylalanine and the infant does not respond to suggestions under "Known reasons for elevated phenylalanine levels."

b. Twice monthly rechecks are advised for those infants showing a level of 10 mg./100 ml. phenylalanine or higher if the physician has not referred the family to one of the centers for diagnosis.

c. If a diagnosis of phenylketonuria is made, quantitative serum and urine phenylalanine tests will be performed at the physician's request. Although the Guthrie has been used as a monitor in several states, there are differences of opinion about using it without any other laboratory work. The Guthrie alone is definitely not adequate for monitoring when levels are below 4 mg./100 ml. or when the child is ill.

Policies Related to Lofenalac® Provided Through the Division of Maternal and Child Health in the Ohio Department of Health

The physician should:

1. Indicate that the family has a financial need.

2. Send a record of the diagnostic blood and urine values, and methods used to determine the values.

3. If the diagnosis was established at one of the centers previously listed this should be stated.

4. Request the amount required for a three months supply (to be reordered two weeks before the family supply is exhausted) and indicate where it is to be sent, i. e., physician's office, parents' home, Local Health Department.

5. Mail a record of test results to the Ohio Department of Health, Division of Maternal and Child Health, Box 118, Columbus, Ohio, at least once every three months. (Not required of Centers.)

6. There have been deaths from phenylalanine starvation which were related to inadequate laboratory monitoring of the diet therapy. Therefore, unless the children are followed at one of the centers, or unless laboratory findings are reported, it is the policy of the Ohio Department of Health to discontinue supplying the Lofenalac.®

New Executive Secretary Takes Office with The State Medical Board of Ohio

NEWLY APPOINTED executive secretary of the State Medical Board of Ohio is William Thomas Washam, M. D., LL. B., former practicing physician in Jackson, and more recently Columbus attorney, specializing in the medico-legal field. Dr. Washam has accepted the post on a part-time basis and will continue to devote some of his time to his law practice.

Dr. Washam fills the post left vacant when Dr. H. M. Platter, retired on December 31, 1965, after 48 years of service with the Medical Board. Dr. Donald F. Bowers, of Columbus, a member of the Board, has been performing the duties of secretary until a successor to Dr. Platter could be named.

A native of Jackson, Dr. Washam practiced there from 1946 to 1962. He is a past president of the Jackson County Medical Society and a former delegate of the Society to the OSMA. Active in community affairs of Jackson, he was twice elected to four-year terms on the local school board and was board president for three years.

Dr. Washam's interest in law developed out of medico-legal cases in which he was called as an expert witness. He began his studies by taking night classes at Ohio State University and Franklin University, commuting to Columbus while continuing his practice in Jackson. He later moved to Columbus as medical examiner for the Bureau of Workmen's Compensation while continuing his law studies.

He received his law degree from Franklin University in 1965 and was admitted to the Ohio Bar also in 1965. He has the distinction of holding top scholastic honors in three fields. He won a Phi Beta Kappa key in 1943, was elected a member of Alpha Omega Alpha medical honorary in 1945, and was made a member of the Order of the Curia in 1964 at Franklin University Law School.

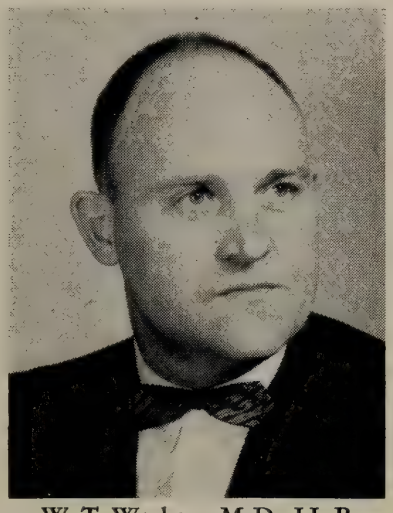
The State Medical Board is the state agency charged with the responsibility of licensing physicians and limited practitioners in Ohio and enforcing the law as it applies to the healing arts.

The board consists of eight physicians, one an osteopathic physician, who are appointed by the Governor with the approval of the Ohio General Assembly. The full term of office is seven years.

The executive secretary is appointed by the Board.

Members of the State Medical Board are the following: Dr. Domenic A. Macedonia, Steubenville, president; Dr. John D. Brumbaugh, Akron; Dr. Donald F. Bowers, Columbus; Dr. J. O. Watson, Columbus, the osteopathic member; Frederick T. Merchant, Marion; Dr. Mervin F. Steves, Cincinnati; Dr. Ralph K. Ramsayer, Canton; and Dr. Lloyd R. Evans, Columbus.

Dr. Washam received his medical degree from Ohio State University College of Medicine in 1945, and graduated cum laude. He took a rotating extern-



W. T. Washam, M.D., LL.B.

ship at University Hospital as a senior in medicine, and a rotating internship at Milwaukee County (Wis.) General Hospital.

He is a member of the Jackson County Medical Society, the Ohio State Medical Association, and the American Medical Association; also the Columbus Bar Association, Jackson County Bar Association, Ohio State Bar Association, and the American Bar Association.

While maintaining ties in Jackson, Dr. and Mrs. Washam and their three children are making their residence in Columbus.

Technicians Receive Certificates In Laboratory Animal Care

Sixteen Cincinnatians have received junior animal technician certificates from the national Animal Care Panel. They were among 35 graduates of a training course for laboratory animal workers which was started in Cincinnati in September 1963. University officials report this to be one of the first courses of its type in the nation.

The course was a joint project of the University of Cincinnati College of Medicine, Children's Hospital Research Foundation, Christ Hospital Institute of Medical Research, and the Cincinnati branch of the Veterinary Medicine Association, groups especially concerned with care for laboratory animals.

'Horse And Buggy' Doctor Retires After 57 Years; Continued House Calls Throughout His Career

'Never Regretted' Giving Up Teaching For Medical Work

Dr. Claude E. Price is a "horse-and-buggy" doctor, but only in a figurative sense. He still cheerfully makes house calls.

But he won't do it for long. The doctor is 88, and after making those calls among his general practice patients all over town for more than half a century, he has announced his retirement—effective at 5 p.m. today.

Before Dr. Price used a "horse-and-buggy" (which he always rented) he either walked or took a trolley car. Even if he rode way out to the end of the old East Broadway street car line, he charged the patient just $2 or $3.

But that was in 1909, when a $5 fee was high. After outgrowing trolleys and buggies, he bought his first auto — a second-hand 1913 Oldsmobile.

Dr. Price, called "the dean of Toledo physicians" by a colleague, notes a gradual but significant decline in the practice of doctors making house calls, except in dire situations. Though he still makes many calls, he admits that most patients don't expect it.

"Young people, in particular, aren't used to that kind of service."

Asked how many babies he has delivered, the doctor answered, "Who knows? My last baby has two kids of her own."

Dr. Price's wife, Ruth, drives him on his house calls, to and from the office, and to Academy of Medicine meetings, which he hates to miss.

During World War II Dr. Price's office nurse joined the navy. So, Mrs. Price, a graduate nurse herself, filled in. She never left. Although she too is retiring today, Mrs. Price still has a lot of work.

"Retiring's no simple procedure," she said. "Retirees don't just throw their old files out the office window, unscrew their shingle, go home, and forget it."

Grew Up On Farm

The Prices were married 48 years ago. When they met, Mrs. Price was a student nurse at Flower Hospital.

The doctor, a native of Indiana, fresh out of medical school at Western Reserve University in Cleveland, might never have come here at all if the Cleveland hospitals hadn't been bursting with interns.

It was almost by chance that young Claude Price became a doctor at all.

He spent his first 22 years on his father's farm near Brookston, a Hoosier hamlet of about 300 (1,202 by the last census). Deciding that he'd like to be a teacher, he enrolled in Valparaiso College and then went on to Indiana University where he was graduated with a master of science degree in his favorite fields, philosophy and psychology.

Before he got a chance to teach, the head of the philosophy department buttonholed young Price and asked him, "Ever thought about medicine?"

"No, not much," was the reply.

Chat With Professor

"Come into my office then, and we'll discuss it," Prof. E. H. Lindley said. "Every time I go into a drugstore, I can barely keep from taking up medicine myself."

Quite a chat, they had.

The young man thought over his professor's words for two days before deciding in favor of medical school (Western Reserve, Class of '08).

"I've never been sorry," the doctor said.

"After all, there's quite a bit of philosophy in medicine," his wife chimed in.

The Prices' youngest son, Scott, also changed horses in the middle of the stream.

Scott was graduated from Michigan State University as an agricultural major, ran a farm for about 12 years, then decided to enter Wayne State University medical school in Detroit. He's now practicing medicine in Dearborn, Mich.

The Prices have another son, Halford, of Lafayette, Ind.; a daughter, Mrs. Maurine Harvey, of Chicago, and 10 grandchildren.

Dr. Price has given his collection of medical books to the University of Toledo.

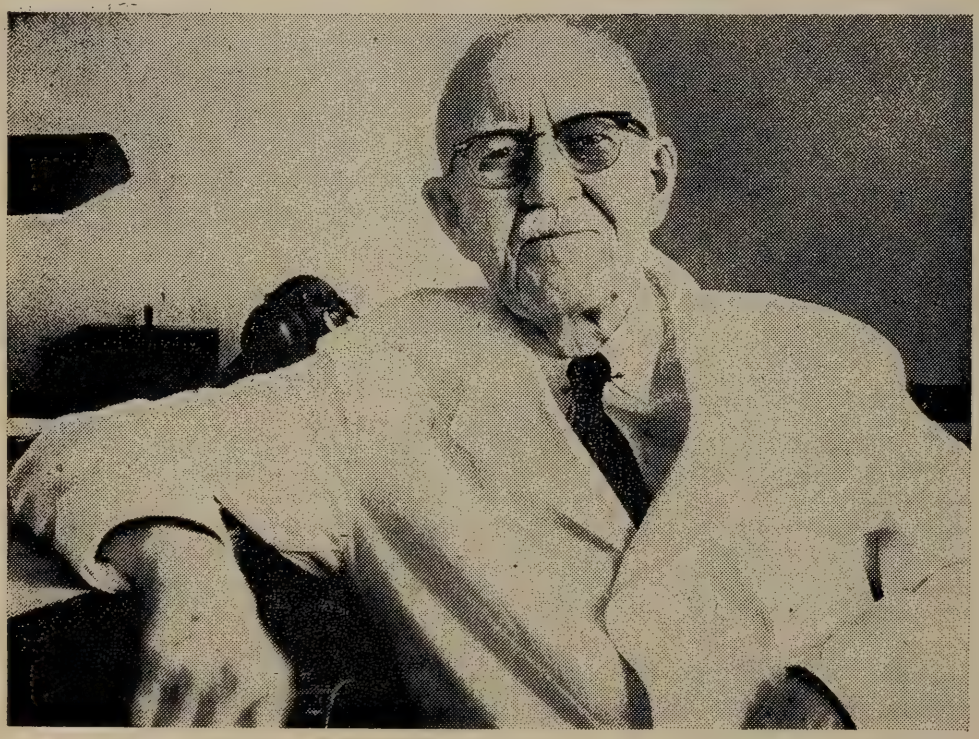
"The books may be old, but the body hasn't changed much either in the last hundred years, has it?" Mrs. Price observed.

The doctor owns a pair of identical and ingenious "patented" examination chairs, manufactured about 1891.

Protruding from each chair's profusion of iron curl, cues are five pedals and umpteen levers. When operated by Dr. Price, the devices permit a patient to be observed in virtually any position.

"I'm going to give one to the Henry Ford Museum at Greenfield Village, if they want it," the doctor beamed.

After today, Dr. and Mrs. Price plan to take it easy at home. They live at 2347 Robinwood Ave.



—Blade Photo

NO MORE STETHOSCOPES, SUGAR PILLS, OR HOUSE CALLS

Dr. Price looks back on nearly 60 years medical practice

Reprinted by Permission from *The Toledo Blade,* June 30, 1966

OSMA Scholarships Awarded . . .

Two Medical Students Will Enter School This Fall under Program, Bringing to Seven Those Receiving Scholarships

DR. LAWRENCE C. MEREDITH, President, on July 15 announced the names of the two winners of the Ohio State Medical Association's Medical Scholarships. The winners are Lawson Charles Smart, of Boardman, a suburb of Youngstown, and Harold Linn Mast, of Smithville, near Wooster. Each of the winners will receive a scholarship of $2,000 ($500 a year) to help meet some of the expenses of medical school.

Smart and Mast were selected from a group of 14 Ohio youths who had completed premedical studies and who had submitted applications for the scholarships.

Smart, the Son of Mr. and Mrs. Lawson C. Smart of Boardman, completed his premedical studies at Mt. Union College, Alliance, where he graduated magna cum laude. He has been accepted in the University of Pittsburgh School of Medicine and will be in the freshman class of 1966.

The Rural Need

Mr. Smart indicated in his application that he felt there was a need for more physicians to practice in rural areas, and it is his desire, after receiving his medical degree, to practice in a rural community.

Fred G. Schlecht, M. D., Youngstown, is Mr. Smart's family physician.

Harold Linn Mast, son of Mr. and Mrs. Glenn M. Mast, Rt. #3, Wooster, will enter the Ohio State University College of Medicine in the Fall of 1966.

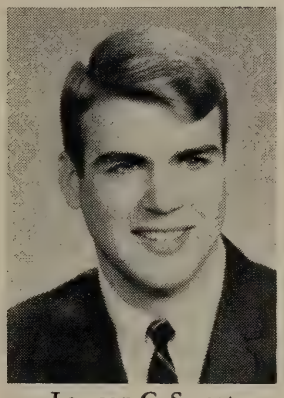
Mast completed his premedicine courses at the University of Wisconsin where he finished in the upper third of his class. Mr. Mast also indicated his desire to become a family physician practicing in a small community, after completing his medical studies.

Mr. Mast's wife, a medical technologist, will work at the Ohio State University to help meet some of the expenses of medical school.

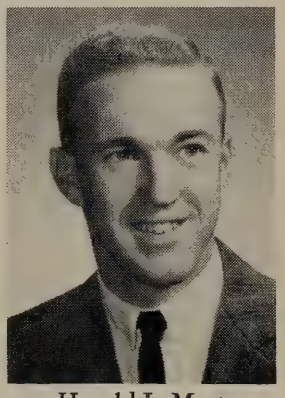
Dr. John Paul Miller, Orrville, is Mr. Mast's family physician.

The two winning applicants were selected in a competition judged on the basis of character, integrity, intelligence, mature personality, interest in community life, leadership and scholastic ability. The scholarships, administered through a Subcommittee of the Ohio State Medical Association Committee on Rural Health, were initiated in 1949 to stimulate among young men and women of Ohio interest in becoming Doctors of Medicine with emphasis on becoming family physicians serving nonmetropolitan communities.

The members of the Scholarship Subcommittee were: Luther W. High, M. D., chairman, Millersburg; Walter A. Campbell, M. D., Coshocton; Jasper M. Hedges, M. D., Circleville; E. D. Mattmiller, M. D., Athens; and Leonard S. Pritchard, M. D., Columbiana.



Lawson C. Smart



Harold L. Mast

Seven in All

In September of this year there will be seven students in medical school who are winners of the Ohio State Medical Association scholarships. The scholarships are a part of the Association's continuous activities to interest medical students in becoming family physicians serving nonmetropolitan communities, as well as assisting these communities in finding physicians to serve their medical needs.

Other such activities include annual programs for medical students in which they are acquainted with this type of practice; a preceptorship program where medical students spend one or two weeks with family physicians; and the Ohio State Medical Association Physician Placement Service.

Dr. William J. Flynn, Youngstown, discussed advances in treatment of cancer at a meeting of the Mount Union College Health Foundation in Alliance. The foundation brings in speakers who discuss medical topics before students interested in medical and nursing careers.

Woman's Auxiliary Highlights ...

Ohioan Is Named President-Elect of National Auxiliary; Keynote Sounded at Pre-Election Conference in Columbus

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

IT WAS WONDERFUL HEADLINE NEWS out of Chicago the last of June! Another outstanding Ohio doctor's wife — Mrs. Karl F. Ritter of Allen County (you read about her in last month's column) — has brought great honor to her state. She was elected to the office of President-Elect at the 1966 convention of the Woman's Auxiliary to the American Medical Association. It is with something akin to humility that we here in Ohio acknowledge gratefully and happily the action of the National House of Delegates. It is only recently that another top Ohio woman — Mrs. William H. Evans of Mahoning County — was honored with the highest office in Auxiliary work and the fact that National has again looked toward Ohio for leadership is — to put it mildly — gratifying and exhilarating. Certainly our pride in Gerby Ritter understandably knows no bounds. (And don't forget that the President of the American Medical Association this year is from Cuyahoga County — Dr. Charles L. Hudson!)

The new National President-Elect needs no introduction. Most of us know well her dedication, her competence and her many years of devoted service in Auxiliary work — on the county, state and national levels. At just this last State convention Ohio added Gerby's name to the limited and privileged roster of honorary members. And now — this greatest honor of all! We are delighted and we offer our warm, ecstatic congratulations. Ohio has done it again!

Your reporter did not attend National convention this year but she did manage to latch on to news tidbits. A record-breaking number of amendments passed and six new directors have been added to the National Board because of the marked increase in Auxiliary membership. There was the traditional, delightful Ohio breakfast, hosted this year at the Drake Hotel by Mrs. James N. Wychgel, state president. I don't know when or how this Ohio breakfast idea got its start at National convention, but based on my own observations other years, it is a time of togetherness and friendship and fun.

Two other Ohio women were named to serve the National Auxiliary this year: Mrs. John D. Dickie, of Lucas County, as advisor to the Program Development Committee, and Mrs. Herbert F. Van Epps, our immediate past president, as North Central regional chairman in Safety and Disaster Preparedness. Mrs. Van Epps served as chairman of delegates. We also came up with another honor — Tuscarawas County won the AMA-ERF award in the 35 to 50 membership category for the largest amount given — $2,650.00. Imagine that — with a membership of 48 women! Shows what can be done when there's the will to do it. Once again, California beat us to the punch for top honors in AMA-ERF with a contribution of $43,562.95 as against Ohio's $38,502.77. (We came in second.) There is some solace in the realization that California's Auxiliary membership is 9,070 and ours 5,599. Yet there is a vast reservoir of untapped memberships in our state. There is so much more than we **can** do — that we **must** do!

Pre-Election Conference

"If the doctors of this nation are too busy to get into politics, then their wives can do it and probably do an even better job." If any words could have been said to keynote the Pre-Election Activities Conference on July 7 at the Pick-Fort Hayes Hotel in Columbus, it was these words of former Vice-President Richard Nixon as uttered at the American Medical Association convention and quoted that July day by Dr. Robert E. Howard, OSMA President-Elect.

This recent outstanding Conference, remarkably well attended, was held under the joint sponsorship of the Ohio State Medical Association, the Ohio Medical Political Action Committee and the State Auxiliary. It was held for Ohio's doctors' wives as a measure of education — as a means of impressing upon them the urgent need for political action. Dr. Lawrence C. Meredith, OSMA President, presided at the morning session and discussed "Why We Are Here." He urged that we "think creatively, think collectively, form key clubs, and act aggressively." All toward one vital end — "to win and win big in November." (There are eight key Congressional races in Ohio this year.) There is little personal glamour in all this, Dr. Meredith pointed out, but "consistent time and effort and elements of every-

day common sense activity can make the woman's touch noted."

Dr. Frank H. Mayfield, of Hamilton County, chairman of the board of directors of OMPAC, discussed his group's objectives and activities. "We had better make sizeable gains in the House of Representatives," he warned, "or else . . ." He said that political campaigns have one, and only one, objective: To win, How are they won? By votes. And how are votes won? For the most part, people make up their minds about what to buy, whether to vote and **how** to vote on the basis of advice from someone whose opinion they respect. OMPAC can become the spearhead of the fight in Ohio, declared Dr. Mayfield, to help in the nationwide battle to keep medicine's friends in the Congress and to retire its opponents. How much OMPAC can do is contingent on whether or not it gets the enthusiastic support of thousands of Ohio physicians, their wives and others, and whether or not they are willing to put up money to back up their beliefs and aims. OMPAC provides financial assistance to Ohio candidates for public office who warrant the support of the medical profession and who may need financial assistance in their campaigns.

Mrs. Frank Gastineau, of Indiana, a past national president and member of the board of directors of AMPAC (American Medical Political Action Committee) presented "AMPAC's 1966 Program." "Ask yourself the question," she urged, "do I really care what happens to my country?" She reminded her audience that campaigns are won by votes and that candidates need helping hands in their campaigns in addition to money. She cited the comment of Senator George Murphy, of California, who said he won because "175,000 women signed up to work for me."

Hart F. Page, Executive Secretary of OSMA, presented an "Analysis of Ohio's 1966 Political Campaign." He discussed the change in Ohio politics being brought about by the reapportionment of the Ohio General Assembly. He urged the doctors' wives to pay strict attention to Ohio General Assembly elections as well as Congressional races.

The afternoon session was presided over by Dr. Howard, President-Elect. "After Medicare, What?" he asked. "The answer is apparent: Those who forced through the Medicare Program will try to ram through additional 'Great Society' health measures." He emphasized that this makes the year 1966 a crucial one, legislatively speaking. An intense fight to keep Congress from enacting additional dangerous medical-health schemes must be launched, he declared.

"You cannot fold up and quit," said Charles S. Nelson, consultant to OMPAC and former Executive Secretary of OSMA. "Even one small gain is a step forward. Each year, build a little more. And **don't** panic." He outlined the following steps that can and have to be taken by local auxiliaries:

1. Get in touch with officers of your county medical society.

2. Find out how many members of the Auxiliary are willing to help; you will need much help. 3. Find out about your Congressional district — the counties



Mrs. Karl Ritter

in your district — the make-up of the individual counties — the type of people, their voting record (such information can be obtained from political leaders.) 4. Get information about the candidates — what are their voting records? — who are the worthy candidates? — get an over-all picture of the candidate, study the man as a whole — get to know the campaign manager as well as the candidate.

5. Ask "what can we do" (no move can be made without the candidate's knowledge and consent). 6. In larger communities, organize pre-registration drives. (There are doctors and their wives who are not registered.) 7. Get voters to the polls. 8. Check on absentee ballots, voters who are sick — go to the hospitals to talk to the patients. 9. Offer services to the headquarters of the party of your choice.

"It's easier to get out the vote when people are scared or mad," Mr. Nelson said. He made one important additional point: Auxiliaries on the local level can do the organizational and background work; then it has to be carried forward as individuals or groups of individuals. (Medical societies can't engage in political activities because of legal barriers; that is why the Medical Political Action Committee was "born."

James S. Imboden, field representative for AMPAC for the state of Ohio and neighboring states, also addressed the conference. "Get into the habit of politics," he advised. "It's a long range project . . . gain a foothold now, at least . . . zero in on what we can do . . . use bumper stickers on your cars . . . display yard sign for candidate . . . line up the Postcard Party, the Coffee Party, the Dial-a-Dozen Program" (more on this in next month's *Journal*). Mrs. James N. Wychgel, state auxiliary president, dis-

cussed "Let's Get the Job Done." "Educate a man," she remarked, "and you educate one person; educate a woman and you educate a whole family." She suggested the use of "tools of the trade" — press clippings, *OSMA-gram, The Ohio State Medical Journal, The Journal of the AMA,* the Legislative Round-Up, the weekly *AMA News, U. S. News and World Report.*

Mrs. Harry L. Fry, state legislative chairman, and George Saville, also an OMPAC consultant and former OSMA Executive Secretary, took part in the lively question-and-answer portions of the morning and afternoon sessions.

Calling Frankie Fry

Do you want to know more about all this? Do you feel you need help in this new field (for us) of political action? Do you need to be stimulated, encouraged, informed even more? Frankie Fry may live in Cincinnati but she's got the legislative wanderlust and no place is too far for her to go, if she thinks she can be of help. She's got what it takes — in enthusiasm, energy and pertinent information. (I'm not her personal publicity agent, believe me!) But I do know how much she has on the ball and I also know how much county auxiliaries need that kind of stimulation and help.

I've had to hold over local activity accounts to make room for this recent and vital Pre-Election Activities Conference. I'm sure you will agree with me that it warrants the priority.

Dr. Irvine H. Page, senior consultant in research at the Cleveland Clinic, received the 12th annual Oscar B. Hunter Memorial Award at the American Therapeutic Society meeting in Chicago.

Dr. Howard D. Sirak, professor of surgery in the Ohio State University College of Medicine, is the author of a new book entitled *Operable Heart Disease —Patho-Physiology, Diagnosis and Treatment.* The publisher is C. V. Mosby Co., St. Louis.

Ohio State University College of Medicine has been awarded a $25,000 U. S. Public Health Service grant to study and evaluate methods of disinfecting inhalation therapy equipment. The cooperative project will be directed by Dr. Colin R. Macpherson, Department of Pathology, and Dr. William Hamelberg, Division of Anesthesia.

Dr. Glen E. Miller, West Liberty physician and secretary of the Logan County Medical Society, has been named Logan County health commissioner on a part-time basis.

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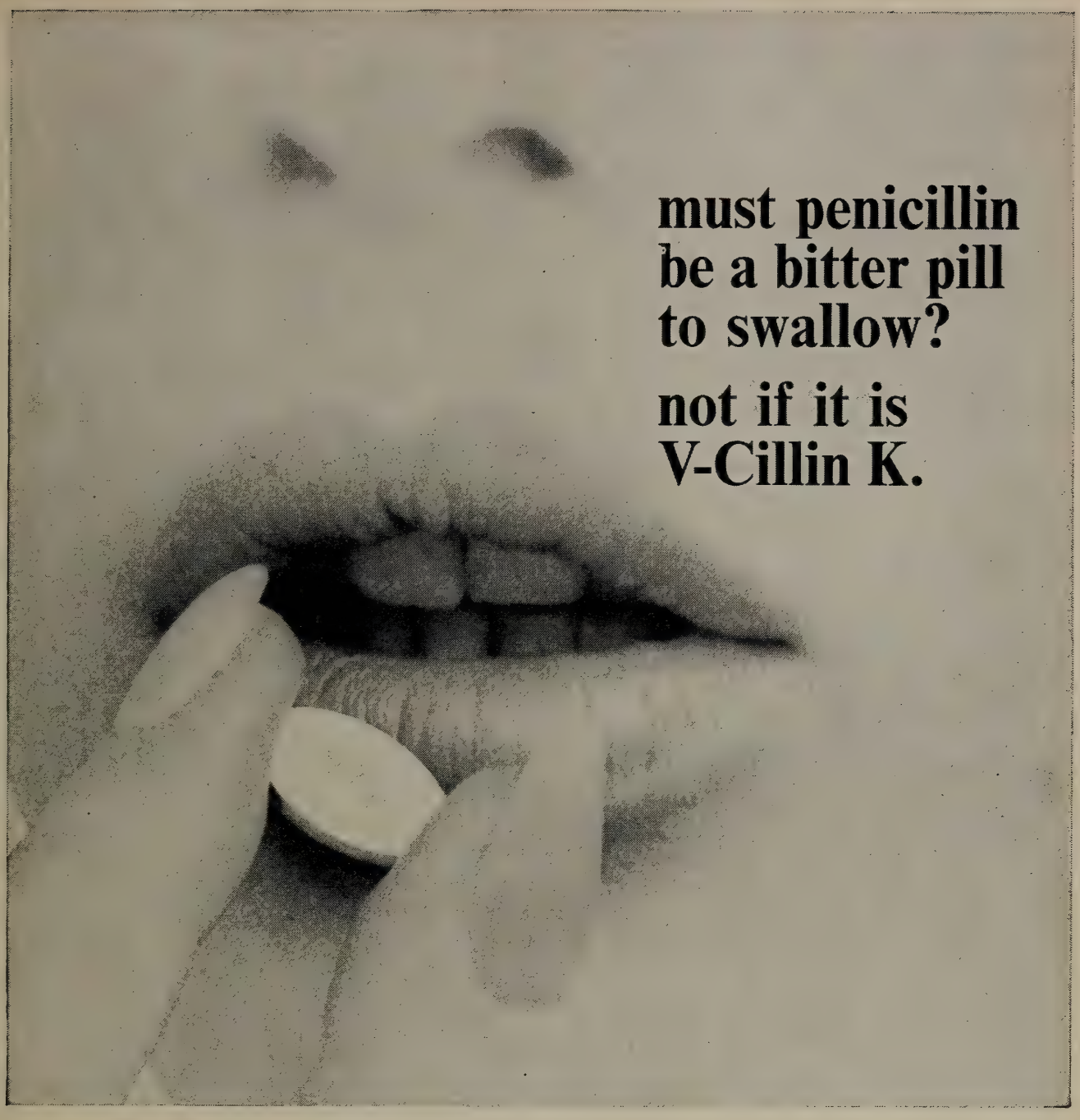
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Ad Astra

J. Herbert Bain, M. D., New Concord; Ohio State University College of Medicine, 1933; aged 59; died June 13; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Born in Bloomfield and a graduate of Muskingum College, Dr. Bain in 1935 assumed the practice of his father, the late Dr. Jacob Harper Bain in New Concord. In addition to his private practice, he was health director for Muskingum College and active in local community affairs; served as president of the Muskingum County Medical Society, and was immediate past president of the Ohio College Health Association; also a member of the Masonic Lodge and the Presbyterian Church. Survivors include his widow and two sons.

Duane Eugene Banks, M. D., Akron; Western Reserve University School of Medicine, 1930; aged 62; died June 15; member of the Ohio State Medical Association, the American Medical Association, and the American Urological Association; Fellow of the American College of Surgeons; diplomate of the American Board of Urology. Dr. Banks moved to Akron in 1932 and practiced there since that time except for a tour of active duty in the Navy Medical Corps during World War II. He was immediate past president of the Cleveland Urological Society, and was a member of the Presbyterian Church. Among survivors are his widow and a son.

Archie A. Boal, M. D., Jacksonville Beach, Florida; Kentucky School of Medicine, 1895; aged 94; died on or about June 17; former member of the Ohio State Medical Association. Dr. Boal practiced in Zaleski from 1896 to 1922 and in Columbus from 1922 to 1962. He is survived by a daughter, in Jacksonville Beach.

Nicholas Edward Clayman, M. D., Cleveland; Western Reserve University School of Medicine, 1928; aged 63; died June 22; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. A practitioner in Cleveland since 1933, Dr. Clayman was associate clinical professor of obstetrics and gynecology at Western Reserve. Shortly before his death Dr. Clayman witnessed the graduation of his daughter, Dr. Julie Ann Clayman, from Western Reserve University School of Medicine. Other survivors include his widow, another daughter and a sister.

John Montfort Finney, M. D., Spokane, Wash.; University of Cincinnati College of Medicine, 1910; aged 85; died June 11. After receiving his medical degree, Dr. Finney moved out of the state, practicing first in Idaho and later in Spokane. Dr. Nancy E. Finney, of Xenia, is a sister. Other survivors include his widow, three sons, a daughter and a brother.

Eugene R. Hammersley, M. D., Tuscarawas; Ohio State University College of Medicine, 1928; aged 61; died May 27; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the American Society of Anesthesiologists. A practicing physician of long standing in the Tuscarawas area, Dr. Hammersley was associated for many years with the Naval Reserve and was a Navy flight surgeon during World War II. Among local affiliations, he was a member of the V. F. W., the Elks Club, and the Lutheran Church. He was past president of the Tuscarawas County Medical Society. Surviving are a son, a daughter, a brother and two sisters.

Theodore P. Herrick, M. D., Euclid; Harvard Medical School, 1919; aged 73; died June 2; former member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of Pediatrics. A specialist in pediatrics of long standing, Dr. Herrick helped found the Northern Ohio Pediatrics Association, and was associated for many years with well baby clinics in his area. He was formerly on the faculty at Western Reserve. Two sons, a brother and a sister survive.

William Henry Price, M. D., Detroit, Mich.; Cleveland-Pulte Medical College, Cleveland, 1899; aged 88; died February 20; practitioner of long standing in Detroit.

James Garfield Powell, M. D., Painesville; Ohio State University College of Medicine, 1931; aged 64; died May 29; member of the Ohio State Medical Association, the American Medical Association, and the Industrial Medical Association. A practitioner of long standing in Painesville, Dr. Powell was a past president of the Lake County Medical Society. During World War II, he served in the Medical Corps overseas. Affiliations included memberships in several Masonic bodies, the Eagles Club, and the Odd Fellows Lodge. Among survivors are his widow, two sons, and his father.

Julius Moses Rogoff, M. D., Bell Island, Conn.; Western Reserve University School of Medicine, 1908; aged 82; died on or about June 28. Former associate professor of experimental medicine at West-

ern Reserve, Dr. Rogoff pioneered in research on the adrenal gland, and was founder of the Rogoff Foundation for Medical Research and Training. Surviving are his widow, two sisters, and a brother, Dr. Herman M. Rogoff, of Akron.

Sarolta Hoffman Selymes, M. D., Cleveland; University of Budapest Faculty of Medicine, 1914; aged 74; died May 24; member of the Ohio State Medical Association and the American Medical Association. Born and educated in Europe, Dr. Selymes came to this country in the early 1920's. He was a practitioner of long standing in the Cleveland area.

Jacob L. Tuechter, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1906; aged 85; died June 24; member of the Ohio State Medical Association, and the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A physician in Cincinnati for some 55 years, Dr. Tuechter was a former president of the Daniel Drake Medical Society and was associated with the American Therapeutics Society, the American Heart Association, and the American Diabetes Association. He was on the faculty of the University of Cincinnati College of Medicine for 20 years. Surviving are a daughter and a sister.

"The Changing World of Medical Communication" will be the theme of the American Medical Writers' Association annual meeting at the Waldorf Astoria, New York City, Thursday, September 29, through Sunday, October 2. Physicians interested in details on this professional organization are invited to write to the national headquarters at 2000 P Street, N. W., Washington, D. C. 20036.

The 12th annual meeting of the Flying Physicians Association will be held at the Dunes Hotel, Las Vegas, September 11-16. National offices of the organization are at 332 South Michigan Avenue, Chicago, Illinois 60604. More than 70 flying physicians in Ohio are associated with the group.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Columbus office during June. The list shows county in which new member is practicing or temporary address in the case of a physician taking graduate work.

Butler
J. Franklin Daugherty, Oxford
Ralph E. Kah, Middletown

Clark
Edwin J. Lilly, Springfield

Cuyahoga
Frank C. Flanders, Cleveland
C. Charles Welch, Cleveland

Franklin
Richard P. Dickey, Columbus

Gallia
Sam N. Rizkalla, Gallipolis
J. Berrye Worsham, Jr., Gallipolis

Mahoning
Domenico Malta, Youngstown

Stark
Frederick G. Germuth, Jr., St. Louis, Mo.

Prototype Refresher Course for Women Physicians Studied

A pilot study designed to evaluate a re-entry into medicine course for women physicians who have been out of touch with the medical profession for ten or more years is the purpose of a contract awarded to the Presbyterian Medical Center, San Francisco, by the U. S. Public Health Service's Division of Community Health Services, Surgeon General William H. Stewart announced.

"Approximately 16,000 female physicians are active in the medical field," Dr. Stewart said. "About 2,600 female physicians are either retired or no longer in practice. Because of the need for more physicians in many parts of this country, the Presbyterian Medical Center study aims to produce a prototype program that can enable other medical centers to set up re-entry courses for women physicians able and desirous of returning to active practice."

Dr. Wesley Furste, clinical assistant professor of surgery in the Ohio State University College of Medicine, participated in the International Conference on Tetanus in Bern, Switzerland, July 15-19.



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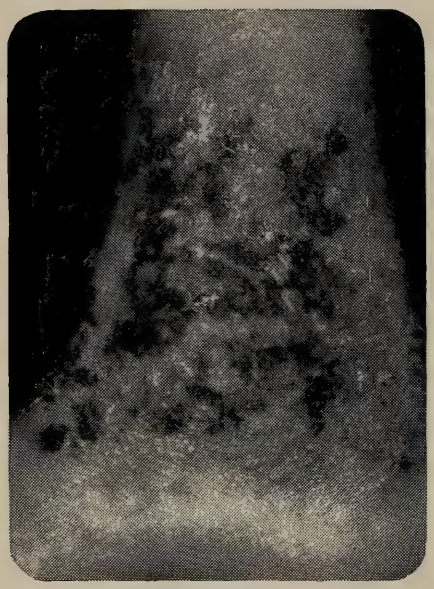
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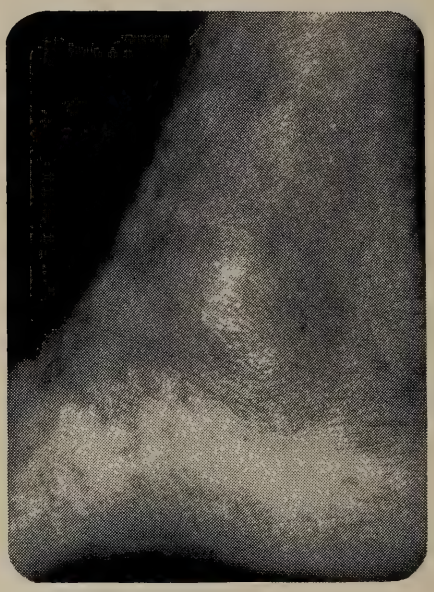
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Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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406-6

Activities of County Societies . . .

BELMONT

The Belmont County Medical Society, with the Auxiliary, met at the Belmont Hills Country Club on June 16 for an afternoon program and dinner. Hugh Hughes, of the Nationwide Insurance Company, Columbus, was the principal speaker for a discussion of Medicare.

COLUMBIANA

Dr. and Mrs. Chester Dewalt of Columbiana shared their cruise around Africa with the Columbiana County Medical Society Tuesday evening (June 21).

Approximately 25 couples attended the society's ladies night dinner at the Wick Hotel. Dr. Dewalt showed slides taken on the cruise this year.

Dr. Edith Gilmore of East Liverpool, society president, was in charge of business. The society's next meeting was announced for July 19 at the Wick Hotel. — *East Palestine Daily Leader.*

CUYAHOGA

Photographs of officers, members of the Board of Directors, officers and directors of the Woman's Auxiliary, for Cuyahoga County are presented in the July issue of *The Bulletin* of the Academy of Medicine Cleveland.

JEFFERSON

Thirty members of the Jefferson County Medical Society dined at the Steubenville Country Club on June 28 and then held a business meeting, with Dr. Jack R. Cohen presiding. Among the items considered were the following:

A Citizens' Committee on Alcoholism suggested the establishment of a facility for the treatment of the acute alcoholic and the rehabilitation of the chronic alcoholic patient.

The Jefferson County Academy of Pharmacy expressed appreciation of the Society on the cooperation in the legislative campaign to control legend-drug advertising in Ohio.

The Resolutions passed at the 1966 Annual Meeting of the OSMA were discussed and explained by Dr. Sanford Press, Chairman of the Legislative Committee and Delegate. Problems relating to Medicare were explored.

In order to encourage physicians to practice in this county, the president announced the appointment of a Doctor Procurement Committee composed of Dr. Lee A. Rosenblum, chairman, Dr. Sanford Press, and Dr. Jonathan J. Yobbagy.

Dr. Jack R. Cohen was recommended as a member of the Board of Directors of the Steubenville Child Development Association.

Because of a recent feature story in *Life* magazine that aroused much public comment, attention was called to a ruling of the AMA Judicial Council by Dr. Aniceto Carneiro, chairman of the Censor Committee, "that it is unethical for physicians to have a financial interest in a drug repackaging company." By parliamentary action, the Society went on record as condemning any financial return by physicians through ownership of drug repackaging firms. — Irving Dreyer, M. D., Secretary-Treasurer.

MAHONING

The Mahoning County Medical Society has established a trust fund for the purpose of providing financial aid to medical and nursing students. The trust will be known as "The Mahoning County Medical Society Foundation." Basis of the fund is the money left over from the polio campaigns conducted by the Medical Society in 1961-62, which amounts to $24,261. Officers of the Foundation are Dr. F. A. Resch, president, Dr. G. W. Cook, Dr. Bertram Katz, Dr. John J. McDonough, Dr. Raymond J. Scheetz, Dr. Frederick L. Schellhase, and Dr. Joseph W. Tandatnick. The Foundation will encourage tax-free gifts from physicians, laymen, and organizations.

MONTGOMERY

Dr. Peter A. Granson, of 355 W. Whipp Rd., has been elected to lead Montgomery County doctors in 1968 as president of the County Medical Society.

Results of the election were announced last night (June 8) at the 117th annual meeting of the society held at Wright-Patterson Air Force base.

Dr. Granson, a general surgeon, will serve as president-elect next year, and become the 119th president of the society when he takes office in 1968.

Other officers elected to serve next year include Dr. Harvey J. Staton, vice president; Dr. Arthur E. Fouke, secretary; Dr. Albert Hirsheimer, treasurer; and Dr. Russell N. Brown, trustee for a three-year term.

Dr. Frank L. Shively Jr. was elected to a five-year term as delegate to the state group and Dr. John Worthman was elected alternate delegate for the same period. Named as senior member to the Clinic committee was Dr. Marcus J. Freese while Dr. Clifford E. Gerhart was named junior member.

The Montgomery County Medical Society president in 1967 will be Dr. William J. Lewis who is now president-elect. Dr. Charles E. O'Brien is the current president. — *Dayton Daily News.*

Law-Medicine Conference Scheduled At Ohio State University

The College of Medicine of the Ohio State University and the Ohio Legal Center Institute have combined their resources to present a special law-medicine conference for Ohio's physicians and lawyers.

The conference is entitled "The Medical Issue," and is directly to the development and presentation of medical evidence in litigation. It affords the physician an opportunity to learn how one should prepare with the lawyer for the giving of testimony. It covers procedures which precede and follow the physician's appearance in court. The purpose and use of the hypothetical questions is discussed in detail with emphasis on the witness' manner of testifying. In this conference, the lawyer will develop an appreciation of the physician's utilization of the source material which constitutes medical evidence and the physician will learn the use the law makes of his findings and opinions.

The program will be given in the 3500 seat Mershon Auditorium on the Ohio State University campus. The dates are Friday, August 19, (9:00 A. M. - 5:15 P. M. EST) and Saturday, August 20, (9:00 A. M - 12:15 P. M. EST.) Only one presentation is scheduled.

The enrollment fee is $40.00 which covers attendance at all sessions, a copy of the extensive printed reference manual prepared by the lecturers, a general luncheon on Friday, and on-campus parking adjacent to the Auditorium. (Those who can attend only selected segments are welcome.)

Persons may enroll with either:

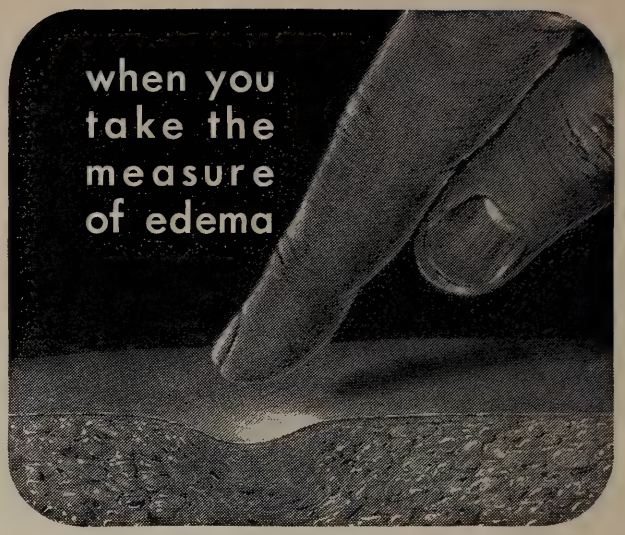
James L. Young, Director, Ohio Legal Center Institute, P. O. Box 8220, Columbus, Ohio 43201; or Dr. William V. Nick, Room 711, University Hospital, 410 West 10th Avenue, Columbus, Ohio 43210.

"Sudden Infant Death Syndrome" Studied Through New Grant

A search for what causes the so-called "sudden Infant Death Syndrome" has been launched under the terms of a $165,300 contract let by the National Institute of Child Health and Human Development, Bethesda, Md., to the Children's Hospital Research Foundation of the District of Columbia.

The little understood medical entity causes the deaths of approximately 10,000 to 20,000 American babies annually, usually in the age group of two to four months.

Dr. James Patrick, chief pathologist at Children's Hospital in the District of Columbia, will head the six-physician team whose work is scheduled for about a year.



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In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Lectures on Human Reproduction Are Scheduled in Cleveland

The Institute for the Study of Human Reproduction invites physicians to attend a non-tuition series of courses scheduled in Cleveland under the title "I. S. H. R. Reviews." Programs are scheduled on Wednesdays from 2 to 4 p. m. in the Conference Room of Saint Ann Hospital, Cleveland.

The Institute, in association with The Saint Ann Hospital, will present Lecture Series No. 5, entitled "New Horizons in Reproductive Physiology and Pathology, November 7-9, in the Academy of Medicine of Cleveland facilities, 10525 Carnegie Avenue, from 5 to 8 p. m. on the three days.

Topics and speakers for the weekly series of programs in September are as follows:

September 7 — "The Cell as a Mirror of Disease," James W. Reagan, M. D., professor of pathology at Western Reserve University.

September 14 — "Prenatal Drug Effects on Offspring," Joseph M. Ordy, Ph. D., instructor in surgery at Western Reserve and research associate at the Cleveland Psychiatric Institute.

September 21 — "Illegitimacy: A Socio-Psychiatric Problem," L. Douglas Lenkoski, M. D., acting director of the Department of Psychiatry at Western Reserve.

September 28 — "LSD and History," Albert Sattin, M. D., Departments of Pharmacology and Psychiatry, Western Reserve.

Watch for additional information on these programs in coming issues of *The Journal.* Details may be obtained from Miss Barbara A. Kasprow, Registrar, Institute for the Study of Human Reproduction, Saint Ann Hospital, 2475 East Blvd., Cleveland 44120.

Dr. William Herman was named Man of the Year for his outstanding services to the community by Gateway B'nai B'rith Lodge, Cleveland.

OSU Medical Education Network Wins Top National Honors

The Ohio Medical Education Network has been named first-prize winner for creativity by the National University Extension Association's division of conferences and seminars.

Dr. William G. Pace is director of the Center for Continuing Medical Education, which sponsors the Ohio Medical Education Network. Robert Schweikart, Ph. D., directs operations of the network. The award was scheduled to be made at a dinner meeting July 24 in Albuquerque, N. M.

The creativity award, given this year for the first time, is to "encourage a deeper appreciation for variety and form in conferences and institutes, as well as to foster originality in programs for adults.

Via two-way radio and telephone, the Ohio Medical Education Network connects the College of Medicine faculty with medical staffs of hospitals in Ohio and West Virginia. More than 50 hospitals participated during the past year. The project began in 1962.

Dr. G. Robert Holsinger, dean of the Division of Continuing Education, said: "Ohio State University is especially pleased to receive the NUEA award because of its emphasis upon the importance of creativity and innovation in the continuing education process.

"Dr. Pace and his staff are to be commended for their development of the concept of the Ohio Medical Education Network, a dynamic illustration of the use of broadcasting in extending the instructional resources of the university far beyond campus limits to meet professional needs."

Dr. John W. Chrispin, of Rockford, has been appointed Mercer County health commissioner on a part-time basis.

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CLINTON—Richard R. Buchanan, President, 115 West Main, Wilmington 45177; Mary Ranz Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

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Ohio Association of Blood Banks Announces List of Officers

Following a meeting held during the Annual Meeting of the Ohio State Medical Association in Cleveland, announcement was made that the Ohio Association of Blood Banks has been formed.

The President is Ludolph H. van der Hoeven, M. D., of Dayton, and the secretary-treasurer is C. R. Macpherson, M. D., Ohio State University Hospitals, Columbus.

Members of the Board of Governors are: Jeanne Burson, M. T., Sandusky; Warren Nordin, M. D., Toledo; Arthur E. Rappoport, M. D., Youngstown; Hazel Suessenguth, M. T., Cleveland; Delores Kreis, M. T., Cincinnati; Robert P. Carson, M. D., Middletown; Mary M. Kastetter, M. T., Columbus; and Donald Walz, M. D., Mt. Vernon.

The University of Cincinnati Medical Center's research program on drug action and efficacy in treatment of man's diseases has received a $10,000 boost from the Eli Lilly Co. of Indianapolis. The division, now 3½ years old, is a joint effort of the university's Departments of Pharmacology and Internal Medicine.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Eye Research at Three Colleges Promoted by Ohio Lions

The Ohio Lions Eye Research Foundation has awarded $24,000 to three groups on the Ohio State University campus, according to Everett R. Steece, general manager.

The College of Medicine, department of ophthalmology; the Institute for Research in Vision, and the School of Optometry will share equally in the funds to support research in diseases of the eye.

Steece, in making the presentation, said the Ohio Lions Eye Research Foundation gives approximately $65,000 annually for research at Ohio State University, the University of Cincinnati and Western Reserve University.

Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal,
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

GENERAL PRACTITIONER. Available immediately position for young G. P. in group practice. Group consists of two G. P.'s, an Internist and an American Board Surgeon, in new medical building with complete laboratory service and close to local hospital. Salary first year leading to partnership, no investment. Rural community, well located in northeast Ohio, excellent school system. Housing available. Reply Box 422, Ohio State Medical Journal.

SPACE AVAILABLE — The Twinsburg Professional Center, on State Route 14, across from the new TWINSBURG PLAZA shopping center, in fast growing Twinsburg village. Air Conditioned, ground floor space available, plenty of parking and good lighting. Western Reserve design. This building is in a five mile radius of Ford Motor Co., General Motors Corp., and Chrysler Corp., and is surrounded by public and parochial schools, churches and approximately 5000 new homes. Eight interchanges in Twinsburg. A dire need for physicians or surgeons in this area due to the expanding population. Mr. Antonucci will make special arrangements for a physician or a surgeon to help them get started and will also arrange housing facilities. A CHANCE OF A LIFETIME. For further information call or write: Mr. Joseph Antonucci, 10570 Ravenna Road, Twinsburg, Ohio. Twinsburg line 425-7141, Cleveland Line 421-7988. For particulars on business conditions contact Philip Johnson, D. D. S., same address, Twinsburg line 425-2220.

ANESTHESIOLOGIST, 41, married, university trained, board eligible wishes to relocate in Ohio. Box 473, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER with ten years experience in active partnership practice desires to relocate in Northern Ohio community. Either association or solo type arrangement would be considered. Will gladly send resume and exchange references. Box 479, c/o Ohio State Medical Journal.

FOR RENT: Office suite, New Medical Bldg. Modern; on one floor; parking space; air conditioned. Call 442-0106 (Cleveland).

OB-GYN man looking for clinic association or good location for private practice. Box 477, c/o Ohio State Medical Journal.

WANTED: Physician; male, under 50, in good health. New Industrial Clinic in Cincinnati. No evening hours. Should have fulfilled or be exempt from military obligation. Attractive remuneration. Frederick A. Wolf, M. D., 911 West Eighth St., Cincinnati, Ohio 45203; Telephone 241-4135.

EXCELLENT OPPORTUNITY for GENERAL PRACTITIONER, INTERNIST and PEDIATRICIAN, with nine-man group now practicing in a rapidly growing suburban community, 18 miles east of Cleveland. Available immediately or will wait for right man. Salary open, leading to partnership. Specialists board certified. Box 475, c/o Ohio State Medical Journal.

FOR SALE: One Burdick Electrocardiograph with portable stand and pro-amp sound projector, new $1200 for $800; 1 vitolator, automatic $132 new for $80; 1 centrifuge, aloe, $98 new for $50; 1 oxygen unit $62.50 new for $30; 1 Health-O-Meter scales $56 new for $25; 1 incubator and counting chamber $42 new for $25; 2 Hamilton cabinet exam tables $100; 1 autoclave sterilizer $25; T. Laurell, M. D., 242 Granville Street, Newark, Ohio. Phone 323-0581.

Anesthesiology — 2-year career residency now available; $10,000 yr. salary; Ann Arbor Veteran's Administration Hospital. Integral part of University of Michigan Anesthesiology Department. Write to Dr. R. B. Sweet, Dept. of Anesthesiology, University Medical Center, Ann Arbor, Michigan 48104.

FOR SALE: Estate sale of otorhinolaryngologist; treatment room equipment; instruments — almost new plastic & stapes; Miller Electric Scalpel; Medical books. Mrs. Morris Hyman, 305 Doctors Bldg., Cincinnati, Ohio 45202.

PRACTICE AVAILABLE in prosperous Central Ohio county seat, due to sudden death of physician; 4-room office, furnished, x-ray and other equipment; records; on rental basis; no investment necessary. Box 481, c/o The Ohio State Medical Journal.

PUBLIC HEALTH PHYSICIAN to assume the duties of Health Commissioner for well established County Health Department. Locale Wood County, Ohio, population 80,000. Headquarters Bowling Green, Ohio, home of the Bowling Green State University. Must be eligible to practice in Ohio, salary open, retirement and fringe benefits. For information contact Louis P. Baldoni, M. D., c/o Wood County General Health District, 541 W. Wooster St., Bowling Green, Ohio 43402.

WANTED: PHYSICIANS INTERESTED IN EMERGENCY ROOM coverage on a fee for service basis. Excellent potential based on approximately 25,000 visits per year. Write: Director, Aultman Hospital, Canton, Ohio 44710.

Conference on Disaster Medical Care Proceedings are Published

Recently released is a 67-page booklet entitled "Summary of Proceedings, 16th National Conference on Diaster Medical Care," being summaries of papers presented at the conference held in Chicago, October 30-31, 1965.

The booklet was prepared and published by the Department of Governmental Medical Services, Division of Socio-Economic Activities, American Medical Association.

Among summaries are those of the following Ohioans who spoke at the conference:

"Resuscitation," by Dr. David S. Leighninger, assistant professor of surgery, Western Reserve University School of Medicine.

"Treating the Radiation Casualty," by Dr. Eugene L. Saenger, professor of radiology, University of Cincinnati College of Medicine.

Ohio Corporation Gets Contract for Artificial-Heart Research

The Monsanto Research Corporation, Dayton, has been awarded a $101,000 contract by the National Heart Institute for research seeking materials that provide the combination of physical and chemical properties most desirable for artificial heart construction.

The contract is one of seven similar awards placed with research organizations, and the corporation is one of 12 institutions for research which received research contracts aimed at the solution of specific problems in artificial heart development.

The National Heart Institute has invested a total of $3,090,284 in the research program, according to an announcement from the U. S. Public Health Service.

Dr. Fiorindo S. Simeone, director of surgery at Western Reserve University School of Medicine, has been named to the President's commission to study the nation's draft laws.



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References: 1. Spencer, Malcolm C. and Becker, S. W., Jr.: **A Hydroquinone Effect,** Clinical Medicine 70:6 (June) 1963. 2. Spencer, Malcolm C: **Hydroquinone Bleaching,** AMA Archives of Dermatology 84:131 (July) 1961.

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VOL. 62 SEPTEMBER, 1966 NO. 9

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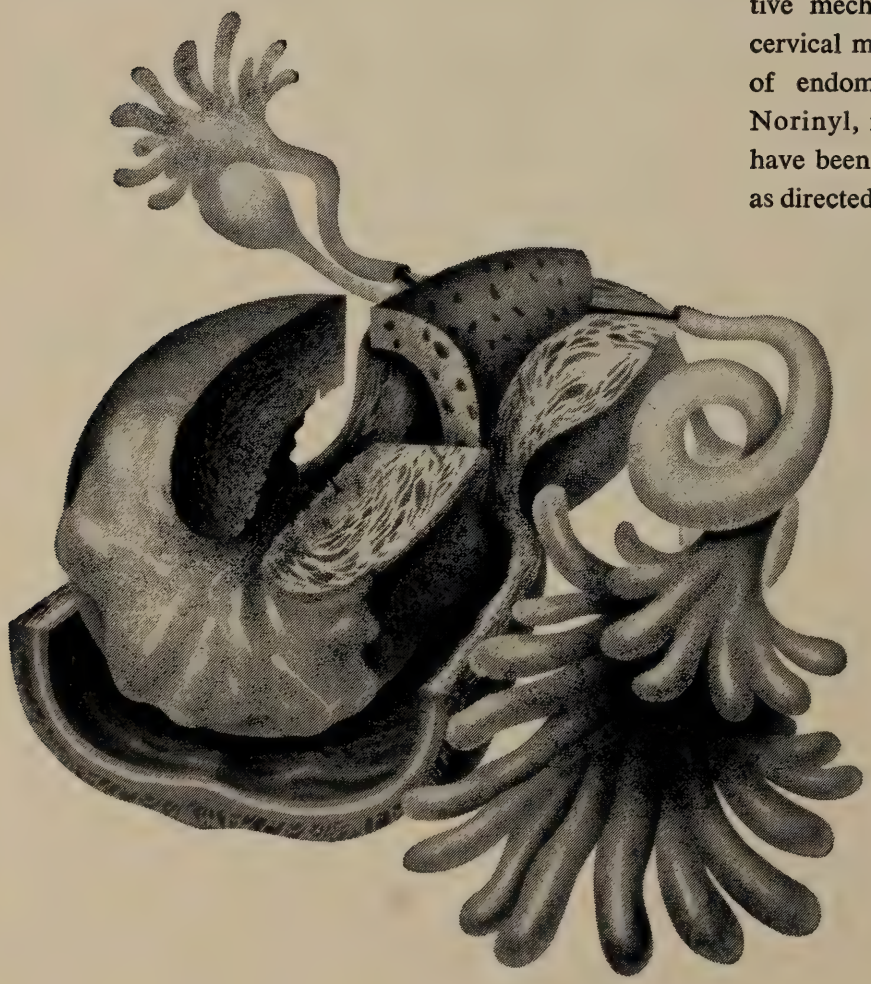
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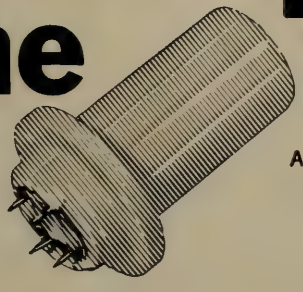
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Query

Is Shingles Contagious?

Editor
The Ohio State Medical Journal
Dear Sir:

Last winter, a nonagenarian patient developed a severe case of herpes zoster. A devoted niece volunteered to care for him; but she wished reassurance on the danger of contagion. I assured her she ran no risk, and that in fifty-seven years of practice I had never seen two cases in the same household. Fortunately, I advised her to consult her own physician. He gave her the conventional answer.

In about six weeks she developed herpes. In another six weeks, I had an unpleasant case, from which I am just recovering. Does this prove that the viruses are getting the jump on us?

In a somewhat puzzled way,

(Signed) MARK HOUSTON, M. D.
321 North Main
Urbana, Ohio 43078
June 25, 1966.

* * *

COMMENT: Chickenpox and shingles (herpes zoster) are caused by the same viral agent. The disease which results is generally believed to depend on the immune status of the patient. Chickenpox occurs with initial infection, whereas herpes zoster is the manifestation in a person who has "partial immunity" from a previous encounter with the virus. Chickenpox is highly contagious for a day or so before the appearance of rash and several days thereafter. Herpes zoster is less contagious possibly because the virus is less widely disseminated. There is none in the respiratory secretions and the localized skin lesions are few in number and usually covered by clothing.

An experience such as that recorded by Dr. Houston has convinced many of us that herpes zoster is contagious or maybe, as Dr. Houston suggests, viruses these days just don't behave like they used to.

The foregoing comment was solicited by the Editor from Dr. Eli Gold, Associate Professor of Pediatrics and Assistant Professor of Microbiology, Western Reserve University, at Cleveland Metropolitan General Hospital, Cleveland, Ohio.

Ohioans on Texas Gyn Program

Dr. Nichols Vorys and Dr. Paige K. Besch, members of the faculty at Ohio State University College of Medicine, will particiate in a Texas program this fall. The University of Texas Graduate School of Biomedical Sciences at Houston, Division of Continuing Education, announced the two-day intensive short course entitled, "Gynecological Endocrinology." The dates are November 16 and 17 and the place is the Texas Medical Center in Houston.

Americans Are Highly Mobile People, Report Shows

Americans are a highly mobile people. Each year since 1948, about one fifth of the population changed residence within the United States, according to surveys by the Bureau of the Census. Between March 1964 and March 1965, the latest period for which data are available, almost 38,000,000 persons 1 year of age or older moved within the country, and an additional 1,000,000 came into the country from abroad.

Most of the moves in recent years did not involve long distances; about two thirds did not cross county lines, and many may even have been from one dwelling to another in the same community. The movers who crossed county boundaries were almost equally divided between those who went to a new home within the same State and those who took up residence in a different State.

Mobility rates vary markedly with age. As would be expected, people in their early twenties have the highest rates for both short- and long-distance moves. In the year ended March 1965, 45 per cent of the people at ages 20-24 and about 36 per cent of those at ages 25-29 changed residence.

Moreover, unlike the experience for the other age groups, more people in their twenties moved from one State to another than to a different county in the same State. Among the factors contributing to the high mobility of young adults are employment away from home, service with the Armed Forces, marriage, and the expanding needs of a growing family. — *Metropolitan Life.*

Cincinnati Physician Is Recipient Of National Pediatrics Award

A. Ashley Weech, M. D., Cincinnati, is 1966-67 recipient of the Abraham Jacobi Award in Pediatrics.

The Jacobi Award of one thousand dollars and a certificate is given by the Section on Pediatrics of the American Medical Association. Established in 1962, it was created in tribute to Abraham Jacobi, founder of the first American pediatric clinic in 1860 and often called the father of pediatrics in this country. The award is made possible by a grant from the Gerber Baby Fund of Fremont, Michigan.

Dr. Weech will receive the award and present the Abraham Jacobi Award Address before the Section on Pediatrics at the AMA Annual Convention in Atlantic City, June, 1967.

Dr. Weech is currently B. K. Rachford Emeritus professor of pediatrics, University of Cincinnati.

Since 1963, he has been editor-in-chief of the *American Journal of Diseases of Children,* a specialty journal published by the AMA.

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

* * *

Government, the physician, and the pharmaceutical industry must join forces to reduce injury from adverse drug reactions. It is industry's responsibility to continue with the development of safer and more effective drugs. It is the responsibility of the physician to use drugs with discretion and to abstain from using potent and hazardous drugs for trivial conditions. It is the government's responsibility, with its virtually unlimited funds and resources, to continuously review and survey adverse experience gained with drugs from all sources and to bring these facts before physicians preferably through already organized channels of medical communication. The government further has a responsibility to remove overly hazardous drugs from the market when usefulness does not balance off against hazard, but it must not use this authority in an arbitrary and capricious manner. The evaluation of drugs for safety is a most difficult and complex matter, and no simple formula can be devised to arrive at a conclusive opinion. — Joseph F. Sadusk, Jr., M. D., to American College of Physicians, New York, April 19, 1966.

* * *

There is much to be gained in most instances by labeling the nature of the medication. Patients are bombarded on all sides by medical information; their approach to medical care is much more sophisticated than that of their parents. The growth of effective pharmaceutical agents has been such that three or four types of medication may be indicated for the management of a single problem. Labeling promotes better medical care rather than detracting from it. Labeling also promotes more effective communication between the patient and the physician. — E. Clinton Texter, Jr., M. D., *Illinois Medical Journal.*

* * *

The problems and responsibilities of government in assuring the safe use of drugs are indeed formidable. . . . This brings up the whole questions of efficacy and of relative efficacy; and who is going to dogmatize on this? Again, who is going to say that the occasional fatal toxic reactions which may result, for instance, from the use of psychotrophic drugs in depressive illnesses are or are not greater than the danger of an increased incidence of suicide if such drugs are forbidden. Doubtless a committee of experts will advise the appropriate Ministers, and if experts are occasionally wrong they are less often wrong than non-experts. Nevertheless, we interfere with the prescribing doctor's final freedom of decision at our peril in a free democracy. It is easy to set up a sort of pontificial therapeutic Establishment; but Establishments — Aristotle and Galen, for instance — have not always been in the van of progress. — Sir Derrick Dunlop, M. D., in *British Medical Journal.*

Clevelander Heads Board of Regents Of American Chest Physicians

Dr. Howard Van Ordstrand, Cleveland, was named chairman of the Board of Regents of the American College of Chest Physicians at the recent 32nd annual meeting of the group in Chicago. Headquarters of the organization is at 112 East Chestnut Street in Chicago.

The following physicians of Ohio were admitted as Fellows in the college:

Ray W. Gifford, Jr., Cleveland; Norman E. Goulder, Columbus; Deane Hillsman, Cleveland; Paul Kezdi, Kettering; R. Gilbert Mannino, Newark; Philip C. Pratt, Columbus; Elias Saadi, Youngstown; G. Douglas Talbott, Kettering; and Glen B. Van Atta, Kenton.

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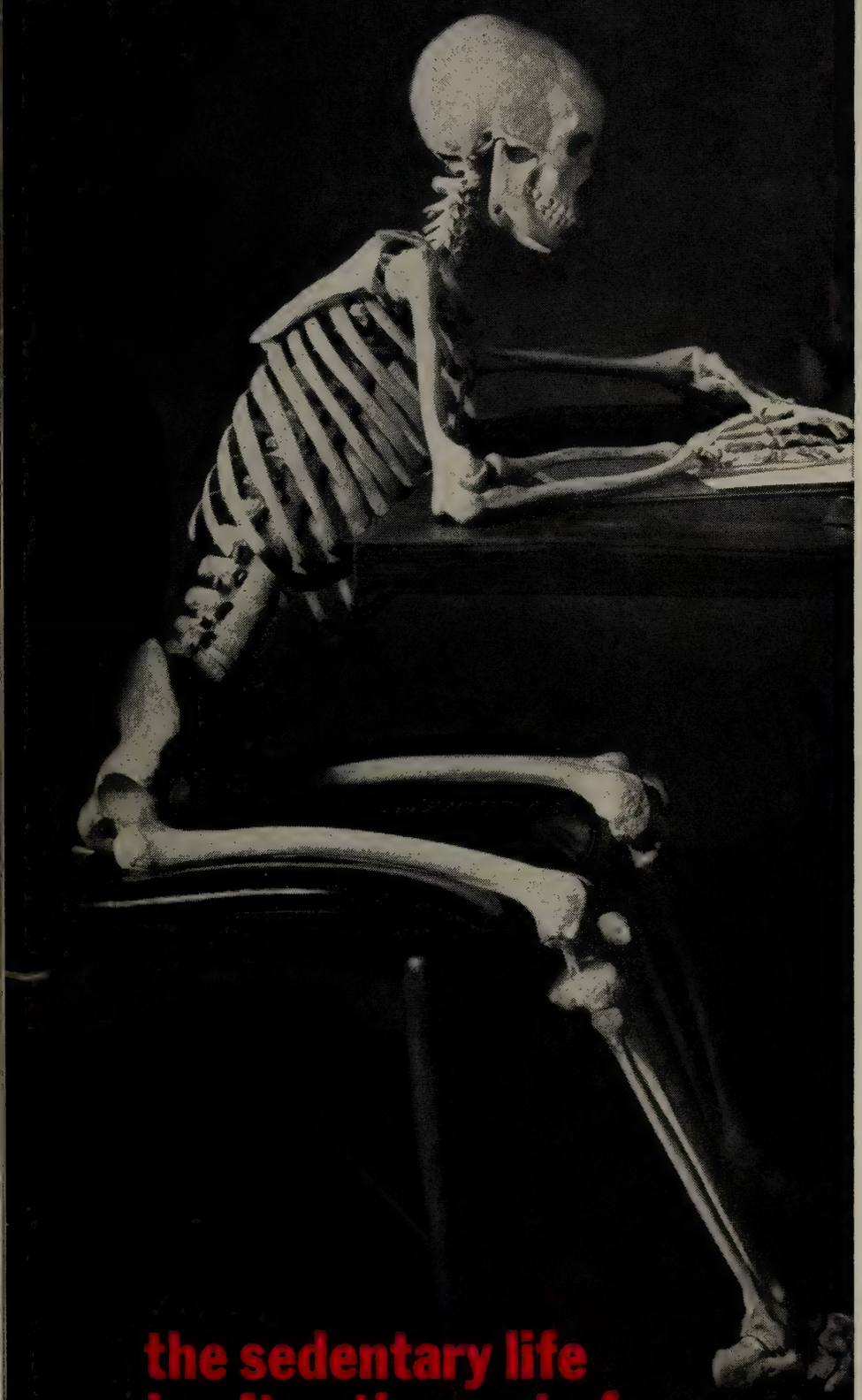
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Anatomy of
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The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

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Related Factors in Increasing Motorscooter Accidents

With more people being killed on motorcycles, motorbikes, or motorscooters, statisticians of the Metropolitan Life Insurance Company give some interesting data on this subject.

Deaths rose from 700 in 1961 to more than 1,100 in 1964 — a 60 per cent increase.

In a substantial majority of the fatal accidents, the operators were committing traffic violations. Reckless driving is a major cause of accidents.

Nine tenths of the motorcycle, motorbike or motorscooter accidents occur when driving conditions are termed "good."

About one tenth of those killed in these accidents are female.

The number of registered motor-driven cycles rose from 596,000 in 1961 to 985,000 in 1964 to nearly 1,288,000 in 1965.

Overturning, running off the road, and other noncollision accidents are responsible for nearly one third of the cycle fatalities.

Deaths per 100,000 vehicles decreased from 118 to 115 between 1961 and 1964. The death toll high for the past ten years was 162 per 100,000 in 1957.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during July. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

Cuyahoga

Bolivar Albainy, Cleveland
Leslie Yu-Lin Cheng, Cleveland
Juan J. Cruz, Wickliffe
William S. Jana, Cleveland
Mario C. Jones, Cleveland
George Stan, Jr., Cleveland
Despina B. Vidalis, Cleveland
Robert S. Yurick, Cleveland

Defiance

Herman W. Reas, Defiance

Franklin

Richard E. Brashear, Columbus
Kenneth N. Carpenter, Dublin
Robert Levine, Columbus
Lowell C. Meckler, Columbus
Stephen Miklosik, Grove City
George W. Waylonis, Columbus

Hamilton

David S. Hill, Cincinnati
Harold B. Spitz, Cincinnati
Richard L. Swarm, Cincinnati

Jefferson

Patrick K. Arakawa, Tiltonville
Fernando J. Manalac, Steubenville
Paul N. Mastros, Amsterdam

Lucas

Pedro L. Jimenez, Toledo
Harris M. Kenner, Toledo

Muskingum

Richard K. Goodrich, Zanesville
James I. Mackall, Zanesville

Summit

Thomas R. Hathaway, Akron
Clifford L. Kauffman, Akron
Luther H. Robinson, Jr., Akron
Constantine C. Roussi, Akron
Russell L. Thomas, Akron

The problems of the facially disfigured — psychological, social and economic, as well as physical — will be studied at the New York University Medical Center under a Federal grant of $100,000.

Ohio Physicians Help Establish Virus Classification System

Two Ohio State University College of Medicine faculty members are part of a scientific team which has advanced a new international system for classifying rhinoviruses.

Dr. Vincent Hamparian and Dr. Robert Conant, both also on the staff of Children's Hospital in Columbus, are principal contractors in a program to clarify the field for research projects involving the rhinoviruses.

A worldwide invitation was issued in 1965 for scientists to submit candidate strains to the typing center in Columbus. Each of 69 strains entered in the program was tested against antiserum. A Committee from the National Institutes of Health reviewed and accepted test data which established 55 distinct types of rhinoviruses.

The classification system sponsored by the National Institute of Allergy and Infectious Diseases, Vaccine Development Branch, was scheduled to be considered by the Ninth International Congress of Microbiology held in Moscow, July 24-30.

VA Hospitals Are Now Providing More Beds for Nursing Care

As of June 24 more than 2,000 nursing care beds were available in 36 Veterans Administrations hospitals in 27 states. A spokesman for the VA said that the program would help relieve the problems which have arisen because of the influx of older veterans to VA hospitals.

The new program was approved by Congress in August, 1964 with additional legislation passed in 1965 enabling the activation and operation of 4,000 nursing care beds. The entire 4,000 beds are expected to be in operation by June of 1967.

Since the beginning of the program in July, 1965, the VA has admitted 2,372 patients and provided them with more than 400,000 days of nursing care. (These figures were given as of July, 1966.) The turnover rate is seven per cent monthly. Other provisions of the legislation enable senior veterans to be assigned to approved private nursing homes for extended care.

According to the announcement, two Ohio area VA hospitals have been allocated nursing care beds: 84 beds for the Dayton hospital, and 201 beds for the Fort Thomas, Ky., hospital in the Cincinnati area.

"The Changing World of Medical Communication" will be the theme of the American Medical Writers' Association annual meeting at the Waldorf Astoria, New York City, Thursday, September 29 through Sunday, October 2. Details may be obtained from the national office, 2000 P Street, N. W., Washington, D. C. 20036.

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Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.
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Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
Before prescribing or administering, read product circular with package or available on request.

Editorial

Cornpicker's Pupil

We all know that anticholinergics cause mydriasis, most of us know that stramonium is an anticholinergic, some of us know that jimson weed produces stramonium, and a few of us know that cornfields may contain jimson weed. Elsewhere in *The Journal* (page 921) is a short clinical note in which Drs. James A. Goldey, Dover A. Dick, and William L. Porter put all of these facts together to explain a patient's puzzling complaint. Following is additional comment on this subject, which we solicited from Dr. William H. Havener, Professor of Ophthalmology, Ohio State University.

"Cycloplegia from accidental ocular contamination by parasympatholytic drugs may affect agricultural workers, medical personnel, or individuals unsophisticated enough to 'try a friend's good eye drops.' We occasionally see it, for example, in nurses, who contaminate their eyes after handling atropine.

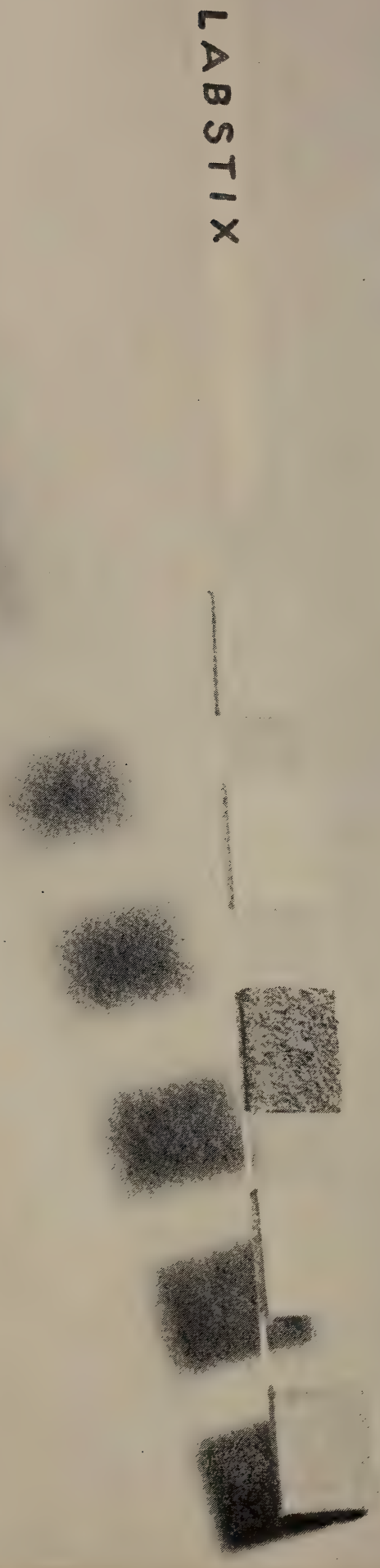
"The differential diagnosis from neurologic disorders causing dilatation of the pupil should not be difficult. The presenting complaint of the cycloplegic patients is visual difficulty of sudden onset, specifically inability to read. Ordinarily the dilated pupil of a neurologic patient is an asymptomatic physical finding rather than a complaint. Furthermore, other evidence of third nerve paresis or cranial nerve disorders will ordinarily accompany neuroparalytic mydriasis. The clue, then, is that the cycloplegic patient notices the dilated pupil and complains about it, while the neurologic patient usually does not.

"Some general observations may be appropriate. The possibility of medical or toxic origin of symptoms or physical findings should be seriously considered in differential diagnosis. Basic pharmacologic knowledge will immediately indicate what categories of drugs might cause given symptoms. Embarking upon extensive and expensive examinations on the basis of an isolated and relatively minor finding of acute and short duration is unwise. Many such problems vanish with a few days' wait, without explanation and never return. Should consultation be desirable, an appropriate specialist should be chosen. Primarily ocular complaints are more likely to indicate ophthalmologic evaluation and care than neurosurgical.

"The authors of 'Cornpicker's Pupil' are to be commended for presenting a succinct, dramatic, convincing, and definitive article."

The Ohio State University College of Medicine has been awarded a $49,322 grant from the U. S. Public Health Service, Bureau of State Services, to support a one-year project of identifying nursing action in the care of postoperative cardiac patients.

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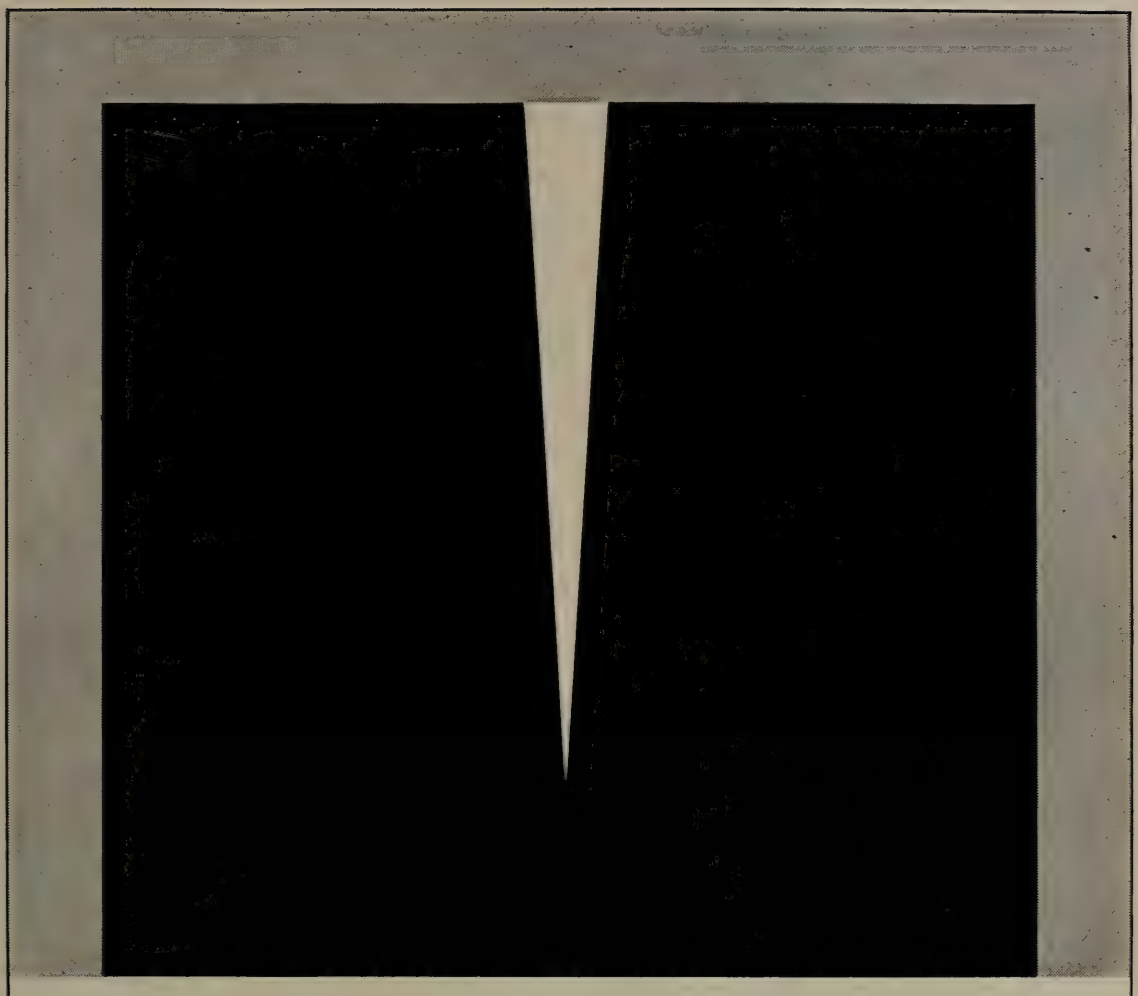
...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

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A good way to describe 'Stelazine'. It's different from the tranquilizers that sedate and dull your anxious patients. Its antianxiety effect is direct. On 'Stelazine', your patients can be calmed yet remain alert.

And 'Stelazine' offers additional benefits. Dependence has not been reported. At low doses, side effects are minimal. Its b.i.d. dosage is convenient and economical.

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brand of **trifluoperazine**

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. *Contraindications:* Comatose or greatly depressed states due to C.N.S. depressants and in cases of existing blood dyscrasias, bone marrow depression and liver damage. *Precautions:* Use with caution in angina patients and in patients with impaired cardiovascular systems. Antiemetic effect may mask symptoms of other disorders. An additive depressant effect is possible when used with other C.N.S. depressants. Prolonged administration of high doses may result in accumulative effects with severe C.N.S. or vasomotor symptoms. Use in pregnant patients only when necessary for the patient's welfare. *Side Effects:* Occasional cases of mild drowsiness, dizziness, mild skin reactions, dry mouth, insomnia and amenorrhea. Neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism) may occur and, in rare instances, may persist. In addition, muscular weakness, anorexia, rash, lactation, hypotension, and blurred vision have been observed. Blood dyscrasias and cholestatic jaundice have been extremely rare.

For a comprehensive presentation of 'Stelazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories, Philadelphia SK&F

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M.D., M.P.H.*

PART III

(Continued From August Issue)

School Health: 1913

THERE were 112 public and parochial schools served by the school health service which was staffed by the Chief School Medical Officer with two district physicians employed full time, and five part-time physicians. A Chief Dental Inspector was also employed full time, four dentists part-time, and two full-time dental assistants. There were 14 school nurses with an average of 2,400 pupils per nurse. The Free Dental Clinic was operated at a cost of $4,500 in salaries. The money for equipment ($1,690) was obtained privately.

1914

In 1914 the population of the city was 402,175 and the total deaths numbered 6,429 (mortality rate 15.98). The infant death rate under one year was 92.6 per thousand births reported and was stated as "one of the lowest in the country." Also, "our diarrheal death rate in infants under two years of age has fallen from 103 per 100,000 population in 1910 to 54 in 1914 and is one of the lowest in the country."

But the tuberculosis problem was still significant with a death rate at "278 per 100,000 for the five-year period preceding 1910; and for the five years following 1910 — 254. During 1914 it was 240."

Disease Prevention

But on the credit side of the ledger, Dr. Landis notes that

Cincinnati's low death rate from typhoid fever since the completion of the filtration plant late in 1907, has led to a partial investigation of vital statistics for the purpose of determining, if possible, the truth of Hazen's Theorem. Briefly this theorem is that one life saved from death by typhoid through an improved water supply means the saving of from two to five more from general causes.

Thus we note in the following tables these improvements:

1905-1907: Before filtration of Water Supply.
The death rate per 100,000 from diarrheal diseases in infants under two years, including inanition and convulsions 133
1908-1910: After filtration 98
1911-1913: After efficient milk inspection 76

Health of Negroes

But Dr. Landis deplores the excessive mortality among Negroes, which

in proportion to their population have three times as many children stillborn, twice as many born alive die during the first year of life, nearly five times as many die of tuberculosis, four and one-half times as many of syphilis, over twice as many from alcoholism, etc. Their general death rate (1913) is a little in excess of 1,005 greater than in the white race. An investigation is now under way to determine, if possible, the reasons why this condition exists; to include sanitary conditions in the home, character of employment, rate of wage, cost of rental, etc.

Sundry Items

The efficacy of terminal disinfection by fumigation is now under suspicion and extensive experiments are being carried on in New York City for the purpose of determining definitely whether or not disinfection by fumigation possesses any real value . . . *(1914)*

The work of the Cincinnati Dental Society in the tuberculosis hospital demonstrated that the nutrition of a large number of patients was seriously interfered with because of bad conditions of their teeth. It is my belief that a nursing force of 15 for work among our tuberculosis poor and provisions for dental care would more than compensate for the additional outlay . . . *(1914)*

As a public health movement, the Better Babies Contest held in Cincinnati on June 25 and 26 was eminently successful. 320 babies were entered. *(1914)*

247 cases were referred to the nurse employed by the Cincinnati Association for the Welfare of the Blind . . . *(1914)*

Education in Health and Work Certificates

Forty-five students were enrolled in a course which includes practical experience in the field demonstrations and routine work in the laboratory. The students were given an opportunity to witness federal and municipal inspection of animals slaughtered, etc.

Begun some six or seven years ago, school medical inspection met the hostility which seems to be everlying in wait for anything in the way of departure from "custom and tradition's hopeless rut." Opposition came from a few of the older principals and teachers and from a limited num-

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.
Submitted March 16, 1966.

ber of physicians and parents. With medical inspectors "on full time" and not permitted to do a private business, the chief objection from the medical profession has been eliminated. The score of our work has been extended until now it includes 115 public and parochial schools. 3,777 children were inoculated against smallpox. Comprehensive examinations of school children were conducted. 17,657 defects were diagnosed. The number of children needing treatment was 16,581 . . .

In accordance with Section 2766 (Laws of Ohio, 1913) the district physicians examined 1,166 applicants for child work certificates. Light work was recommended for six children who were deformed or handicapped by organic lesions . . .

In January the Department of Health undertook for the Board of Education a course in elementary hygiene and the care of the sick for A grade girls of the Woodward High School. The 15 lessons took up 30 hours of school time over a period of 19 weeks. The girls were taught how to appoint a sickroom, etc.

Vital Statistics: 1915

The death rate in 1915 was 15.63 per 1,000 population. The city's population was 406,706. But the death rate for the colored part of the population (estimated to be 22,005) was 29.40. There were 7,804 births — a general birth rate of 19.19 per 1,000 population.

Tuberculosis Control

Dr. Landis writes with some satisfaction,

The intensive work of the past five years is having cumulative effect enabling the city to break all previous records along several lines, the lowest general death rate in history. The tuberculosis death rate at the lowest point in many years at 2.20 per 1,000 population. The infant mortality down to 78 per 1,000 live births, and so on. The effect of an improved milk supply on infant mortality (from 547 deaths in 1906 to 175 in 1915). Of course, in the interval the population had risen from 345,230 to 406,706 persons.

In the laboratory over 1,000 more samples were examined. The routine procedure for the diagnosis of diphtheria is to make cultures on Loefler's blood serum of the swabs submitted. These cultures are incubated at 37.5°C for from 8 to 16 hours. During the year 1,853 cultures were examined for diagnosis of diphtheria of which 458 were positive . . . Also, tubercle bacilli were found in 648 of 2,239 specimens of sputum examined. Some 900 agglutinations were performed for Typhoid, Paratyphoid and Enteritis infections . . . 69 were positive, etc.

Dr. W. H. Peters: 1916-1934

In a "triennial" summary published in 1918, Dr. Wm. H. Peters, the Health Commissioner writes:

In presenting a brief summary of the more important phases of work performed under the leadership of the late lamented Dr. Landis, we believe that the people of Cincinnati will concur in our opinion that real progress has been made commensurate with appropriations for public health purposes. We regret that we have not been able because of funds to publish annual reports for the last three years . . .

1. . . . In discussing a program for the future, I should like to stress particularly the need for increasing the medical and nursing service so that we can furnish prenatal and postnatal service and provide adequate dispensary service for tuberculosis individuals and suspects, and give a little more attention to the Negro health problem . . .

2. The number of inspectors in the division of Sanitation, Food and Drugs should be increased and if we are to continue in the front rank, it is imperative that we create two new divisions — one of Public Health Education and the other of Industrial Hygiene and Occupational Diseases . . .

3. Needless to say that if we do these things there will be a compensatory drop in the death rates . . .

4. There should be a well-organized campaign for the control of cancer which is a common enemy of mankind. Cure depends upon early diagnosis and treatment. One woman out of every eight past the age of forty dies of cancer. Drugs may relieve pain, but they do not remove the cause. The only hope of cure lies in early surgical removal.

5. The epidemic wave of infantile paralysis reached Cincinnati in July, 1916, throwing the populace into a frenzy of fear. It continued throughout the hot, dry and dusty months. Children under 16 returning from infected centers in the East were kept under observation. 10 sporadic cases occurred in 1917 with no fatalities while 1918 showed an increase with 23 cases reported and 2 deaths.

6. Typhoid fever, with a death rate of 3.2 per 100,000 was the best record in the history of the Queen City.

7. We favor the more general application of the Schick Test as an economic procedure in the control of diphtheria . . .

8. The great prevalence and severity of whooping cough in recent years led to the making of new quarantine regulations requiring the placarding of homes and the wearing of a band on the arm of the child afflicted . . .

9. The great white plague, tuberculosis, claimed in 1916 as its toll, 926 victims; in 1917, 952; and in 1918 there were 940 fatalities.

The Influenza Pandemic

The great pandemic of influenza in its western flight struck Cincinnati the last few days in September, 1918. The first death occurred on October 1st. A most alarming situation soon developed and became almost beyond control. The Board of Health had wisely foreseen the gravity of the epidemic and measures were promptly taken a week in advance of other cities to combat the scourge. Being forearmed with a ban on all gatherings, the closing of theatres, churches, schools, and the regulation and limitation of saloon trade, the regulation of stores and shops for the prevention of crowding, and variety of measures for the promotion of individual and community hygiene, we were unquestionably enabled to save many hundreds of lives. It is estimated that there were about 100,000 cases with 1,688 deaths from October 1st to December 31st, 1918. In 1918 the mortality being 4.07 per 1000 population.

Gonorrheal Ophthalmia

160 cases of inflammation of the eyes of the newborn were reported by midwives and physicians during the first three years. Of this number 50 were pronounced "Gonorrheal Ophthalmia" . . . In 18 no prophylactic had been used at birth. Four children died under treatment. Loss of the right eye in one case, left eye in two cases was noted. 65 cases of trachoma, reported to the Department, were followed up in order to instruct the patients as to the proper prophylaxis in the home . . .

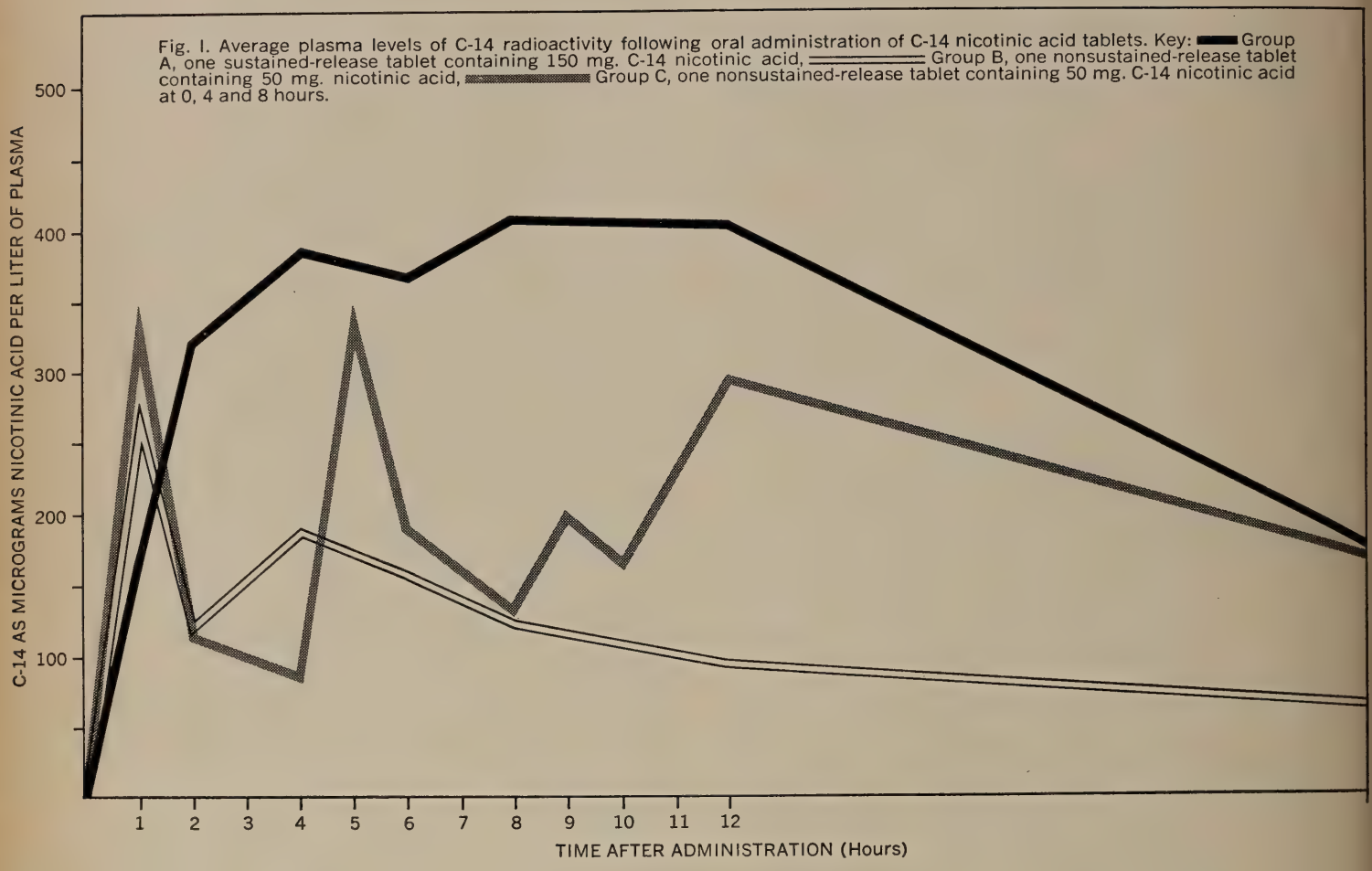
Child Hygiene

Under "child hygiene" in nine infant welfare centers milk was provided for the poor through the Taft endowment . . . A "Baby Week and Better Babies" contest was held in 1916. The "Oyler Health Center" was the scene of "intensive work" . . . notwithstanding the baleful influence of the influenza epidemic which played such havoc in the nineteenth ward.

(Continued in October Issue)

Sustained circulatory, respiratory and cerebral stimulation for the

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

Ideal for geriatric patients

- ☐ provides gentle, dependable overnight relief
- ☐ offers aid in restoring normal bowel tonicity and peristalsis
- ☐ no griping or cramping; no added bulk

"In our experience, this combination/Modane/has been more satisfactory in handling chronic constipation of senile bedridden patients than most other laxatives . . . a 93 per cent response was obtained in a general hospital population."*

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Danthron in Modane acts selectively on the large bowel; its gentle stimulation assures overnight relief of constipation.

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Pantothenic acid plays an important role in the formation of acetylcholine. An adequate level of acetylcholine is necessary for normal transmission of neural impulses to intestinal muscle.

one tablet daily with evening meal

Modane Tablets—75 mg. danthron, 25 mg. d-calcium pantothenate.
Modane Mild Tablets—37.5 mg. danthron, 12.5 mg. d-calcium pantothenate.
Modane Liquid—37.5 mg. danthron, 12.5 mg. d-calcium pantothenate per teaspoonful (5 cc.). **Dosage:** One tablet, or palatable liquid dosage, with evening meal, or as required by patients.

*Plotnick, M.: Int. Record of Med. 173:262, 1960.

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What To Write For

Some booklets, pamphlets, and other published materials available for the asking or at nominal expense and suitable for the physician's office, library or waiting room or for his personal information.

Report of the Committee on the Control of Infectious Diseases, or the "Red Book" of the American Academy of Pediatrics. This 15th edition of the well-known report contains recommendations for immunization, and other procedures for infants and children. $1.50 from the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

* * *

Current Procedual Terminology, 1st Edition; a booklet containing a system of standard terms, provisional eponyms, and descriptors developed for the convenience of physicians and designated personnel to expedite the reporting of therapeutic and diagnostic procedures of surgery and medicine. $2.00 in the U. S. Canada and Mexico; $1.50 for medical students, interns and residents.

* * *

Identifying Problem Drinkers in a Household Health Survey. Field procedures and analytical techniques developed to measure the prevalence of alcoholism. A good narrative description as well as statistical data. USPHS Publication No. 1000 - Series 2 - No. 16. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 — 35 cents.

* * *

Supply, Demand and Human Life. A leaflet directed toward public support of the national campaign to recruit additional volunteer blood donors, in a joint effort supported by eight organizations including the American Medical Association. Copies available from the American Association of Blood Banks, Central Office, Suite 1322, 30 North Michigan Avenue, Chicago, Illinois 60602.

* * *

Nurse-Physician Collaboration Toward Improved Patient Care. A report of the second national conference of physicians and professional nurses held September 30 - October 2, 1965, in Denver. Order from Department of Nursing, American Medical Association; $1.50 per copy.

* * *

A Doctor Talks to 5-to-8-Year-Olds. One of a series of booklets to aid the physician in his talks with patients. Write for list and details to the Budlong Press Company, 5428 N. Virginia Avenue, Chicago, Illinois 60625.

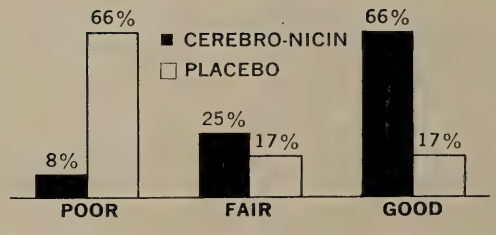
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forgetfulness
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in the aging patient

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EACH CEREBRO-NICIN CAPSULE CONTAINS:

Pentamethylene Tetrazole	100 mg.
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Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	2 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentamethylene Tetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.
Federal law prohibits dispensing without a prescription.

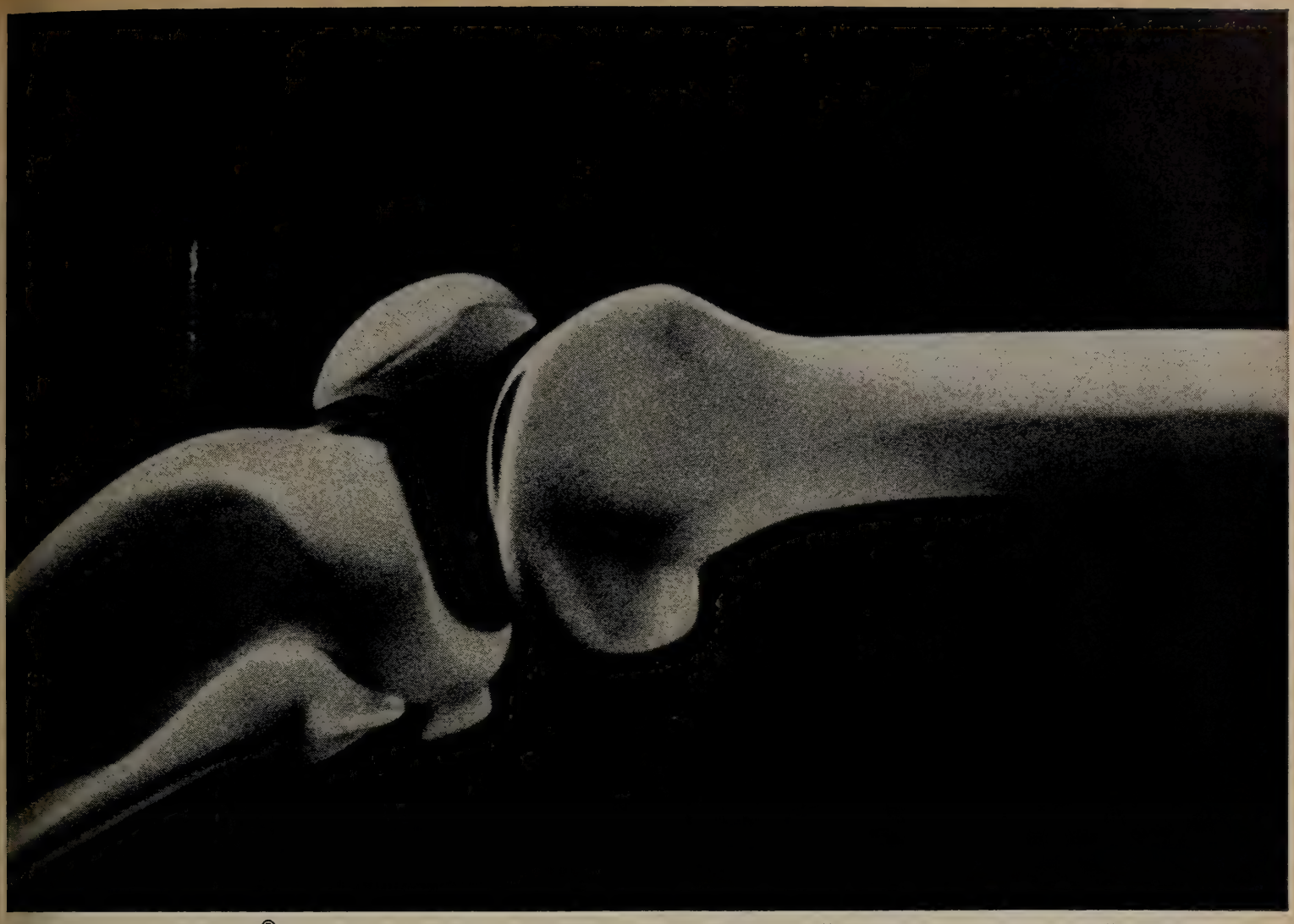
CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jrnl. of the Amer. Ger. Soc., June, 1964.

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Butazolidin® alka

phenylbutazone, 100 mg.
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Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
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American College of Surgeons To Convene on West Coast

The 52nd annual Clinical Congress of the American College of Surgeons, will be held in San Francisco, October 10-14.

Every phase of surgery will be presented during the five-day program through 261 research-in-progress reports, nine postgraduate courses, 42 panel discussions in general surgery and surgical specialities, 107 medical films, 14 operative telecasts from Palo Alto-Stanford Hospital, and 425 scientific and industrial exhibits. Approximately 1,100 doctors will be participants in the program.

Details may be obtained from ACS at 55 E. Erie St., Chicago, Illinois 60611.

Malignant Tumors Studied

Dr. Dante G. Scarpelli, professor of pathology at Ohio State University, is continuing an investigation of aflatoxin and its relationship to cancer of the liver in rainbow and brook trout, under a grant from the National Institutes of Health.

Hatchery-raised rainbow trout have a high incidence of liver tumors not ordinarily found in wild trout. Grain is a component of the diet of hatchery-raised fish, and aflatoxin is found in moldy grain.

Investigators Compile Collection Of Papers on Berylliosis

An interesting collection of reprints of articles on Beryllium poisoning by a Northern Ohio group of investigators, has been bound in booklet form.

The original clinical research on the various acute manifestations of Berylliosis was performed by the group with a follow-up which has extended over 26 years. One of the investigators reports that the disease has been adequately controlled, but that the answer has been elusive as to the method of its peculiar selectivity and delayed manifestations, especially of the chronic form.

Authors of the papers are: Morris G. Carmody, M. D., medical director of Clifton Products, Painesville; Joseph M. DeNardi, M. D., Lorain, senior instructor in Department of Medicine, Western Reserve University; John Zielinski,† M. D., Lorain, medical director of the Brush Beryllium Company; and the following physicians of the Cleveland Clinic Educational Foundation: George Curtis, M. D., Department of Dermatology; Robert Hughes, M. D., chief of the Department of Radiology; Earl Netherton, M. D., emeritus consultant in dermatology; and H. S. VanOrdstrand, chairman of the Medical Division and chief of the Department of Pulmonary Diseases.

Inquiries may be directed to Dr. DeNardi at 736 Broadway, Lorain.

†Recently Deceased

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American College of Physicians Announces Regional Programs

The American College of Physicians has announced its list of regional programs to be held in areas throughout the nation from September through June of 1967. Details about all of these meetings may be obtained by writing the college at 4200 Pine Street, Philadelphia, Pa. 19104.

Here are some of the programs in the immediate vicinity of Ohio:

Regional meeting for Ohio, Western Pennsylvania, and West Virginia; Morgantown, W. Va., January 20-21, 1967.

Michigan Regional meeting, Detroit, November 18-19.

In the category of postgraduate courses, the ACP will sponsor a program at the University of Cincinnati College of Medicine, June 12-16, 1967, on the topic, "Internal Medicine — Current Physiological Concepts in Diagnosis and Treatment."

A course on "Fundamental Concepts of Gastroenterology" will be held at the University of Michigan Medical Center, Ann Arbor, March 20-24.

A program on "Psychiatry for the Internist," will be given at Wayne State University School of Medicine in Detroit, March 27-31.

Establish Training Program for Obstetric Anesthesiology

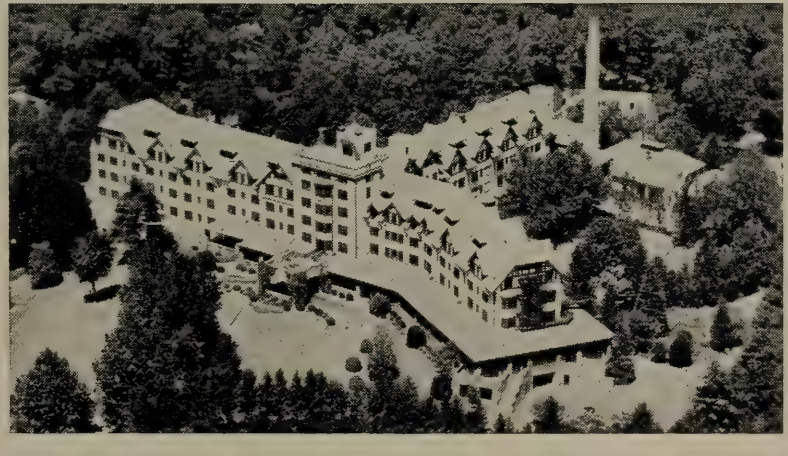
What is reported to be the nation's first regional training center in obstetric anesthesiology is being established at MacDonald House, maternity hospital in Cleveland's University Medical Center, it was announced by Dr. Douglas D. Bond, Dean of the School of Medicine of Western Reserve University.

The program will be supported by a two and a half year pilot training grant awarded to University Hospitals of Cleveland and the WRU School of Medicine by the Children's Bureau of the Department of Health, Education, and Welfare. Present value of the grant is $234,000 through 1968, and it is expected that the program will be extended beyond that year.

The new center will provide physician specialists six months of intensive training. An objective of the program is to train at least eight physicians per year to fill positions of directors of anesthesiology for maternity hospitals.

The grant provides yearly stipends of $10,000 to be paid to trainees who have had one or more years of practice or postgraduate studies after residency. Anesthesiologists or obstetricians who have completed two years of residency will receive $8,000 per year. Obstetric and anesthesiology centers of the United States and Canada have been invited to nominate trainees to the center.

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Asheville, North Carolina



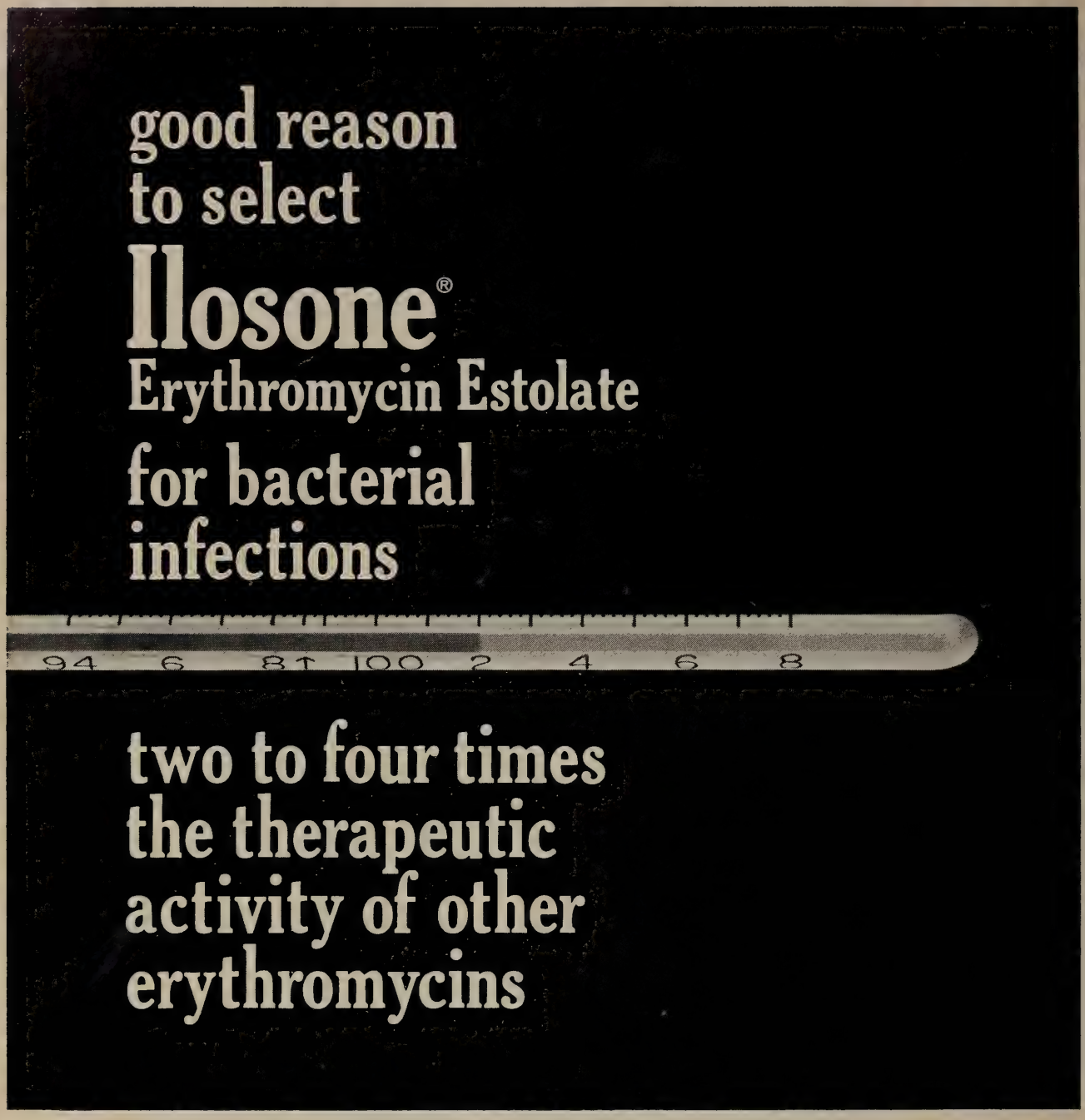
An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients

Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

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For rates and further information write APPALACHIAN HALL, Asheville, N. C.



CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Additional information available to physicians upon request.
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Computers in Cardiology

A Look Toward the Future

G. DOUGLAS TALBOTT, M.D.

THE roles of computers are assuming an increasing importance in medicine and particularly this seems to be true in the broad field of cardiology. As one views numerous medical installations of various disciplines and regards the world cardiological literature, the roles of computers appear to categorize themselves into patient care, basic research, teaching, literature storage and retrieval, nutritional research, and administration.

Monitoring

Patient care, as it pertains to cardiology, concerns itself mainly with the monitoring of the acute medical or surgical patient, although some emphasis should be placed on the diagnostic and therapeutic implications of computers.

Substantial gains are being made in the monitoring field, which offer tremendous potential in the care of the acute patient.[1-7] While the author's main experience has been with the care of coronary patients, there have been excellent facilities constructed and substantial progress made with the postoperative patient undergoing surgery for vascular, congenital, and degenerative disease.[8-10]

Whether the patient be medical or surgical, the basic principles involved in monitoring are similar. Heretofore measurements, whether physiological, biochemical, electrophysiological, or hematological, have been intermittent and sometimes random: blood pressures read at intervals of 15 minutes to four hours, blood counts once or twice a day, electrocardiograms every 24 hours, pulses, temperature, and respiratory rates every four hours, lactates and pyruvates once daily, are time intervals commonly observed in daily practice. Such procedures lead to empiric characterization, not only of the disease in general but also of the particular stage of disease with which the physician is currently dealing.

All physicians are aware that any acute cardiology patient presents a swiftly changing condition, one which may alter appreciably from minute to minute, and certainly belies conclusions drawn from either random or intermittent measurements. However, it is manifestly impossible to take readings by conventional methods on all the pertinent variables at intervals frequent enough to delineate the successive steps in a continuously dynamic state. If enough hands and eyes could by some miracle be available to accomplish that purpose, then the time required to record and correlate the data would nullify the effort, insofar as

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Submitted January 3, 1966.

treatment is concerned. Fortunately, to free us from such a dilemma, computers now exist. Microsecond measurements of multiple variables can be made on a continuous basis by process-control computer. Such a computer confers three distinct benefits.

First, instantaneous information is available as to the real-time or current status of the patient.[11,12] Such information can be displayed digitally, by means of analogue-to-digital conversion, at the bedside (See Fig. 1). Thus it becomes possible to stand at the foot of a patient's bed and view readings of his blood pressure, pulse, temperature, and respiration as of the moment of observation. This information is delivered through body and catheter sensors in digital form (Fig. 2), and can be transmitted to automatic typewriters to provide both permanent nursing records and material for subsequent medical study. Intermittent but frequent blood chemistry studies and other physiological observations can already be made of blood withdrawn through arterial and venous indwelling catheters. Eventually it will be possible to do real-time monitoring of not only the rate but also the rhythm and wave-form of the heart's activity. The point is that a process-control computer allows both physician and nurse to have precise knowledge of multiple physiological variables in the acutely ill patient at any given moment. (See Figs 3 and 4.)

The second major benefit of computer monitoring is conferred by the double-checked alarm system. A major source of difficulty in the mechanized unit for intensive care, or in the coronary ward, is the problem of false alarms. Time and again when a very complex and expensive system is installed in a coronary ward the alarm system virtually negates the benefits of automation by its many false-positive signals.

To interpose a process computer system between the "stand alone" units and the patient provides two advantageous checks: redundancy check and cross-correlation check of multiple variables. An apparently out-of-limit pulse rate, for example, would be checked as follows. The pulse rate would be checked repeatedly (redundantly) on a multisecond basis to be sure that the alarm had not been actuated by sensor stoppage, change in position, or such common phenomena as coughing or sneezing. In our currently operating computer system at Cox Coronary Heart Institute, where multiple measurements are being made on many variables in normal subjects, at 4000 points an hour, we have found that false alarms from such causes occur frequently, and can be compensated for by redundancy checks. Cross-correlation checks reveal the behavior of multiple physiological variables, simultaneously. Such revelation allows the physician to anticipate and possibly to prevent cardiovascular disaster.[13] Cross-correlation checks are made on two bases: the on-line nursing record shows simultaneous second-to-second variations in multiple variables, while the on-line graphs reveal trends in the movement of those variables.

When a single variable, such as the pulse rate, is out of bounds it is important to know what other related variables are doing. If the pulse rate is really out of limits, then other hemodynamic parameters should also be abnormal. A single variable only briefly in alarm strongly suggests artifact. A combination of variables out of limits generally heralds either shock, failure, or other cardiac catastrophe. The sophistication of computer interface permits us to make both repeated individual and multiple simultaneous observations so that we may more promptly and accurately recognize true alarm and differentiate it from false alarm.

The third benefit of computer monitoring lies in the rapid accumulation and processing of massive data from multiple measurements. Massive data has too often been a curse rather than a blessing. A thoughtful, well organized and sophisticated plan pre-programmed for massive data processing must first be formulated and propagated. If this is done, one may pass from empiric characterization to general and later to analytical characterization of a given state, and thence into a quantitative description of the disease entity. In our institution such a plan for data processing has been evolved by our data team over the last several years and thus far appears to be satisfactory. Of course the latter steps in analytical characterization are in their infancy, and require additional time for their evaluation.

Diagnosis

The diagnostic use of computers in the interpretation of electrocardiograms has almost passed from the research phase into the service phase, due to such pioneers as Caceres, Pipberger, and others.[14,28] Similar progress in routine and commonly used laboratory studies has been accomplished by such workers as Reeves, Ramelkamp, Maloney,[29] and others.[30] Pulmonary function studies are already being computerized by Graybiel's group at Pensacola. While many problems still need to be resolved, the future of computers in interpretation of physiological measurements seems assured.

More complex is the diagnostic use of computers in the interpretation of such symptomology for the identification of specific disease states, such as congenital heart disease.[31,33] Homer Warner's early work in this area has emphasized the importance and potential of such an approach.[34] Although its initial use may be in the field of teaching, eventually a service function will be realized.

Therapy

Even more distant and perhaps more obscure are the therapeutic implications of computers in cardiology.[35] Consider for example, the acute myocardial infarction patient brought into the coronary ward in

	TIME	PAT	DIA	SYS	HR	RR	TEMP
	12 35 58	1	HR	OUT HI	V 75	L 75	
	12 36 04	1	71	96	75	0	98.6
	12 36 34	1	64	88	76	0	98.6
	12 37 04	1	71	96	77	0	98.6
	12 37 34	1	72	92	80	0	98.6
	12 38 04	1	64	89	79	0	98.6
	12 38 34	1	72	94	81	0	98.6
	12 39 04	1	69	95	79	0	98.6
	12 39 34	1	65	90	78	0	98.6
	12 40 04	1	66	89	80	0	98.6
	12 40 34	1	65	94	79	0	98.6
	12 41 04	1	71	91	81	0	98.6
	12 41 34	1	74	92	81	0	98.6
	12 42 04	1	68	91	83	0	98.6
	12 42 10	1	HR	UPPER	FROM 75	TO 90	
	12 42 12	1	HR	IN HI	V 82	L 90	
	12 42 34	1	68	91	81	0	98.6
	12 43 04	1	55	84	80	0	98.6
	12 43 30	1	HR	OUT HI	V 92	L 90	
	12 43 34	1	83	113	92	0	98.6
	12 43 48	1	HR	IN HI	V 88	L 90	
	12 44 04	1	73	102	88	0	98.6
	12 44 28	1	HR	OUT HI	V 90	L 90	
	12 44 30	1	HR	IN HI	V 89	L 90	
	12 44 34	1	62	85	88	0	98.6
		1	HR	OUT HI	V 90	L 90	
	12 44 38	1	SYS	OUT HI	V 176	L 164	
	12 44 42	1	SYS	IN HI	V 158	L 164	
	12 45 04	1	71	94	97	0	98.6
7	12 45 34	1	75	101	98	0	98.6
6	12 46 00	1	SYS	OUT HI	V 175	L 164	
5	12 46 04	1	72	167	92	0	98.6

FIG.1. *Automated nursing record.*

profound shock. Assuming that vasopressor agents are the treatment of choice, most physicians have had the experience of attempting to administer such agents manually. The nurse taking frequent time-logged cuff measurements, and the physician adjusting the stopcock on the I. V. bottle by guess as to the appropriate drip rate, inevitably combine to produce the "ping-pong" phenomenon of pressure overshoot and undershoot with its obviously undesirable effects. Yet it is quite possible, with indwelling arterial-pressure transducer and a servomechanism involving pressure feedings through the computer, to use a graded pump system to administer a vasopressor in a much more quantitative and real-time related fashion.[36,37] Such a system is now possible in our laboratory and, in the author's judgment, will ultimately replace the present unsatisfactory manual method by virtue of its precision and physiological soundness.

So we see that the computer has already demonstrated its usefulness in many areas of cardiological patient care and promises to give us still newer vistas of improved survival and recovery.

Modeling and Simulation

A very important area of application of computers in cardiology is in the "modeling" of physiological systems and processes. A model, in this sense, could be loosely defined as any mathematical or physical analogy that is used to describe the important aspects of a system and to demonstrate how these aspects are interrelated. For example, hydraulic system models can be built that serve as a physical analogy of some aspects of the circulatory system, and mathematical equations can be developed that describe such things as the dye-dilution process used for measuring the cardiac output.[38-45]

As more complex physiological processes are studied, the equations which define their mathematical models become too complex to be solved by manual methods. Such models can, however, be defined by running their equations on a computer which provides both solutions and outputs, such as the time variation of the variables considered in the model. Developing a model whose output will truly represent the known physiological system is, in most cases, a long process with much trial and error and many reiterations before an acceptable solution is obtained. Here again the computer gives us the capability to run a model over and over again while making complete changes in its structure, or while varying parameters to optimize a solution.

In all of this, we must not lose sight of the primary purpose of developing a model, which is to obtain insight into the physiological process. The use of computers and mathematical modeling is a means of discovering quantitative relationships. Such relationships provide much more information than the mere qualitative cause-and-effect relationships which are so commonly sought in medicine today.

Trying to develop a model forces a degree of discipline and provides a method of organization in the study of complex systems where there are many interrelating and related factors. It provides a method for developing and testing hypotheses in ways that would be impossible when working with the actual living system. As with any powerful analytical tool, the use of the computer imposes much more stringent requirements upon the medical researcher, and creates more potential pitfalls, than the use of more conventional procedures. Measurements and observations must be much more precise, mathematical techniques must be much more sophisticated. The maximum effective use of the computer will require considerably more education in the physical and mathematical sciences than is presently provided to most physicians. However, it is our feeling that the surface has just been scratched and that the rewards will be commensurate with the effort expended by those willing to learn to use computer techniques in medical research.

Nutritional Research

Analysis of individual nutritional histories and the formulation of diets has assumed increasing importance paralleling increasing knowledge of saturated fats, sodium, carbohydrates, and total calorie intake as related to cardiovascular disorders. Several studies have shown the merit of computer control for such analysis and formulation.[46,50] Though a long and tedious programming effort is required, computer systems are now capable of rapidly breaking down a detailed individual dietary record to determine basic food elements, minerals, and caloric content. Such a system will eventually lend itself to inquiry from a practicing physician. By means of a diet history sheet he may be able to find out what undesirable dietary habits his cardiological patient possesses, without the presence of highly trained and skilled nutritionists and dietitians. He then can begin to formulate a desirable diet. One of the major benefits of such a system is the identification of hidden dietary sources of saturated fats and sodium, as well as the rapid and accurate formulation of desirable diets.

Literature Storage and Retrieval

Temporal restrictions do not allow detailed discussions of the significant and growing role of computers in cardiological world literature.[51,54] Suffice to say that by means of computer it is now possible to store and to selectively retrieve an almost unlimited number of abstracts dealing with specific problems of the heart and blood vessels. One such specific inquiry system for coronary disease has been developed at Cox Coronary Heart Institute, and is described in detail elsewhere. But whether the subject be

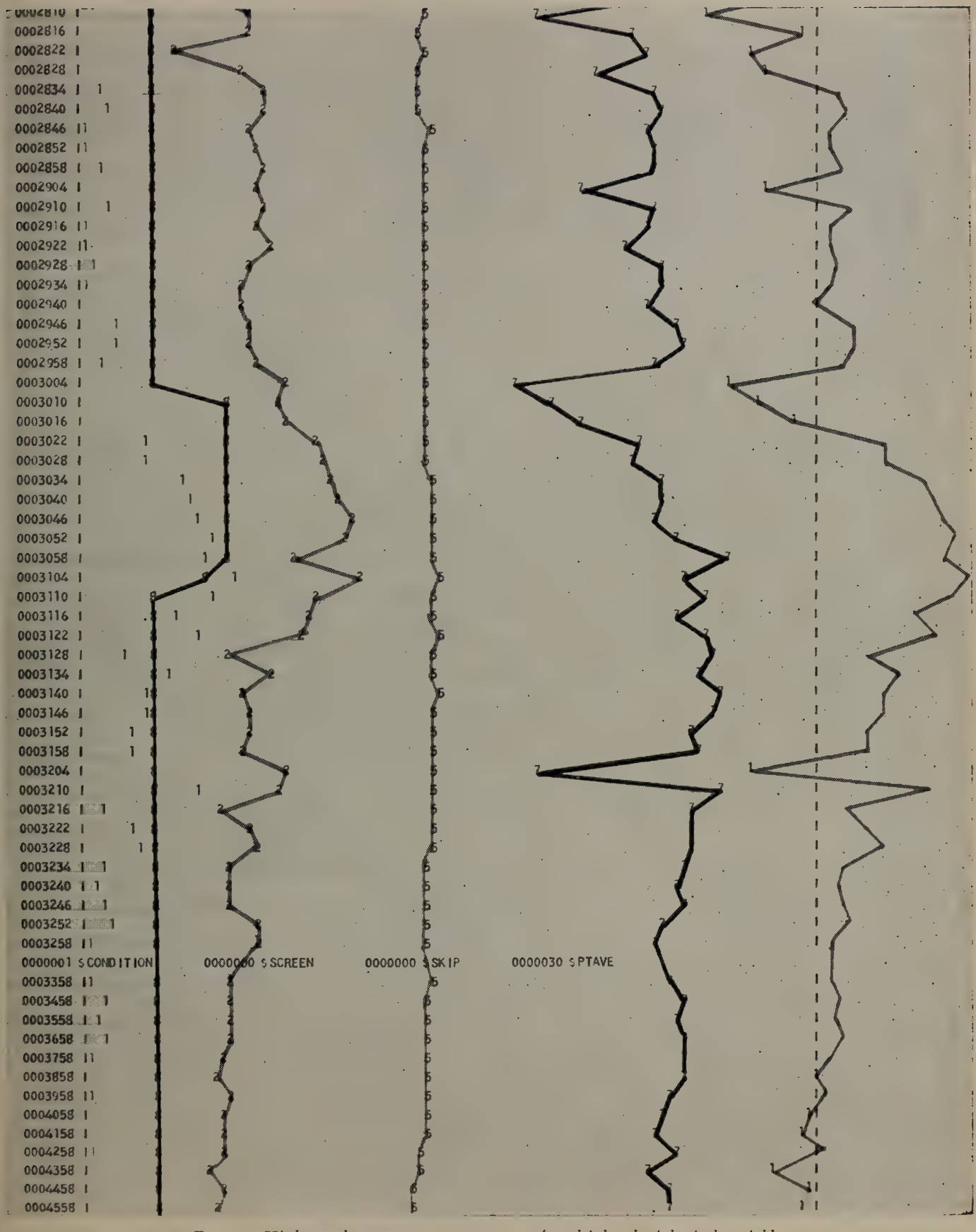


FIG. 2. *High-speed computer measurement of multiple physiological variable.*



FIG. 3. *On-line computer graphing of systolic blood pressure.*

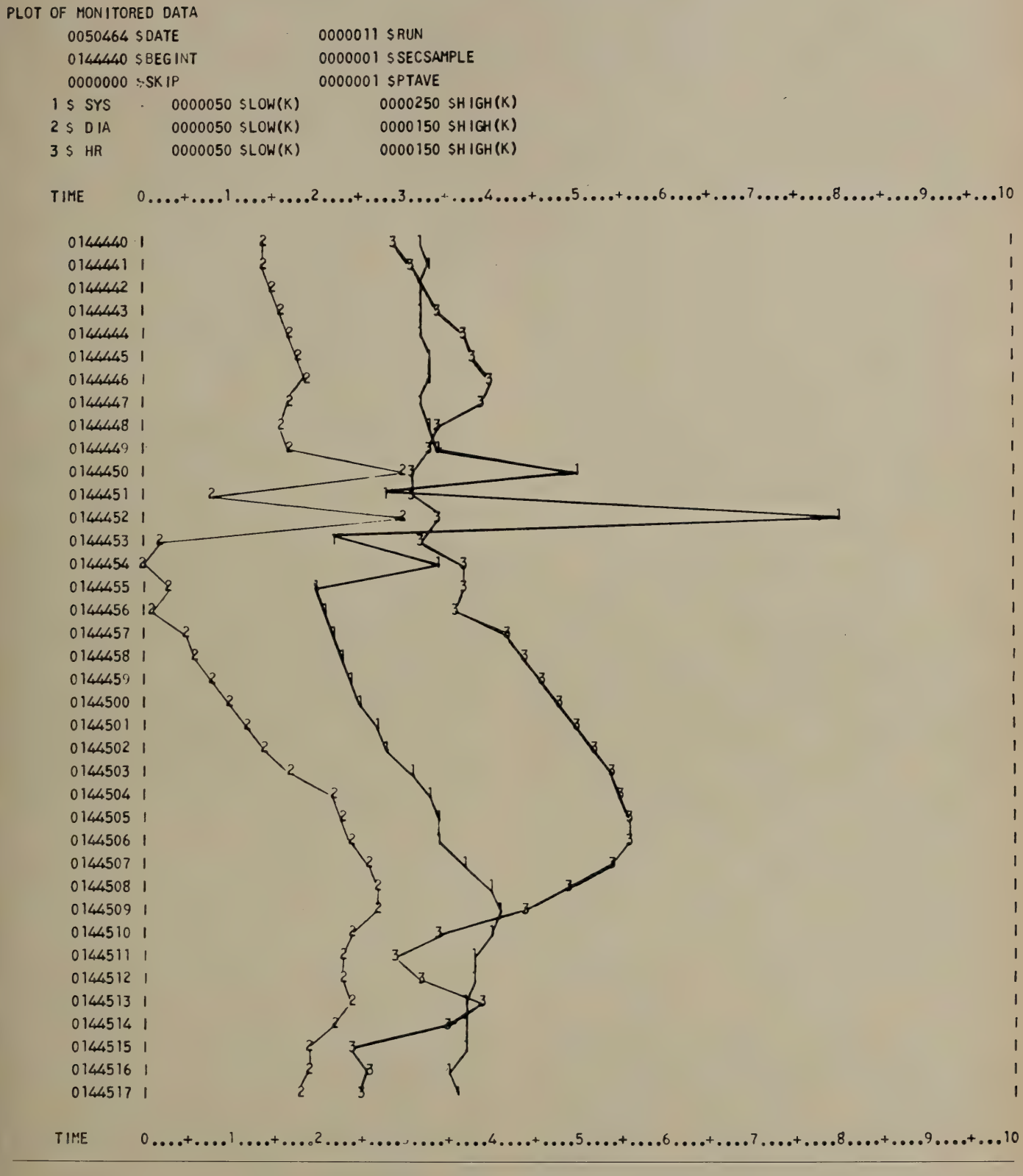


FIG. 4. *Thirty second multiple variable computer-recall record.*

vascular degenerative disease, congenital heart disease, acquired valvular disease, or any of a host of other cardiological disorders, computer systems can now be programmed to store and retrieve authors, key words, abstracts, and even complete documents. Original document storage by computer techniques today is wasteful, but retrieval through microphotographic methods such as PCMI offered by National Cash Register, or through the microcard offered by IBM, offers a partial solution.

Systems such as this permit not only specific inquiry, ie, retrieval of a set of specific abstracts in response to a specific question, but also offer the advantage of remote inquiry. Inquiry can be made from a distance by use of remote output devices such as automatic typewriters, which have output speed of 180 lines per minute, or by cathode ray tubes. Visualization of the material requested may be forthcoming in a few minutes, although the inquiring physician may be hundreds of miles from the computer center. The main limitation of such systems today is not the technology of the computer but the lack of medical data-basis with pertinent abstracts translatable into machine language. The future of such literature specific inquiry systems is bright indeed in its promise to practitioner, medical student, research physician, and consultant.

Other Computer Applications

In addition to those mentioned there are diverse other applications of the computer in cardiology.

The potentials of computers in the teaching field have already been indicated by such investigators as Warren and associates. Because of the computer's vast memory capacity and its ability for cross-correlation, it is probable that in the future the computer will be queried with an almost infinite number of questions relating to specific symptoms, disease entities, and syndromes. Medicine is not unique in that it must await advances in both computer technology and education of the public to realize this goal. Several major industries and the corporations are devoting large sums of money and much time in advancing such technology and in hastening such education, for industry is confident of the computer's future.

Sophisticated machine-teaching and learning methods have the distinct advantage of removing the limitations of both time and teaching-manpower for a given student.[55] Machine-teaching allows great flexibility in rate of individual student-learning, and potentially represents a mass memory bank superior to any given individual's retention and recall. Consequently, individual students may set their own learning pace with the computers. Obviously it would be a tragedy of concept if such learning was not subjugated to the human teacher, and secondary to his influence and wisdom.[56]

Computers in cardiology will have broad administrative capabilities.[57] An example is maintenance of patient records.[58-61] Today, in a short period of time a patient may successively enter four or five different hospitals in any given city. Each hospital starts a new chart in which earlier and often valuable information from other hospitals obviously is not included, and the distance-time factor does not allow the current attending physician to be privy to such material. At some future time, centralized computer patient-record banks will be used with automatic peripheral output devices at the individual hospitals. Uniform record forms will be used in all member hospitals. All of the accumulated medical information on any given patient will be available to the current physician. Before this can be realized many problems must be solved: privileged communication, doctor education, layman acceptance, and medical agreement on a standardized record. Despite these multiple difficulties, such central computer record-control will eventually be available not only for cardiological patients but for patients of nearly every category.

Another example is in computerized drug control. The manual stocking and distribution of all kinds of drugs and therapeutic agents are not only clumsy but often wasteful procedures. Furthermore procurement of vitally needed drugs is often delayed because the drug inventory is not up to date. The Department of Defense, and industries such as those which supply parts to the automobile and the airplane manufacturers, have already utilized computers to solve these problems in logistics. Medicine will do likewise.

A third administrative use of computer is for bookkeeping. It has already been demonstrated that financial and administrative bookkeeping in the hospital can be done more efficiently and more quickly by computers.

Summary

In the cardiology of tomorrow, computers will play an increasing role. Their worth to the patient suffering from degenerative vascular disease has already been proven in many of the areas discussed, but their accomplishments are dwarfed by their potential. Despite the enormous and intriguing possibilities offered by the technology of machines it is still important to remember that the course and survival of the cardiological patient will forever depend fundamentally on the human factor. However, computer and automated systems offer the physician an opportunity for greater sophistication in diagnostic and therapeutic techniques. Inevitably, better patient care and longer survival will result.

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References

References are available from the author.

Resuscitation After Cardiac Arrest

Case Report of Two Successful Resuscitations Four Years Apart

A. IAN G. DAVIDSON, M.B., Ch.M., F.R.C.S.(E.), and DAVID S. LEIGHNINGER, M.D.

FOLLOWING is the report of two fatal heart attacks occurring in the same patient at ages 69 and 73 years.

Case Report

The patient, a 69 year old white man complaining of persistent chest pain, was seen by a cardiologist on December 12, 1959. An electrocardiogram at this time revealed an old posterior myocardial infarct and the presence of possible digitalis intoxication accompanied by runs of paroxysmal atrial tachycardia. It was decided that the patient should be hospitalized but, while in the admitting office of University Hospitals, he collapsed and was immediately taken to the nearby emergency room. Occasional respirations were noted but no pulse could be felt. Mouth-to-mouth breathing was started. An emergency thoracotomy was done to permit direct massage of the heart.

The interval between collapse and the start of massage was estimated at three to four minutes. Ventricular fibrillation was present. After endotracheal intubation the patient was ventilated with 100 per cent oxygen. Despite poor myocardial tone, a good circulation was maintained by hand pumping. The heart was defibrillated by two 110 volt shocks (A.C.). The blood pressure was then 130/90 mm. Hg. The electrocardiogram showed frequent runs of ventricular tachycardia. Procaine amide 300 mg. was given intravenously but ventricular fibrillation recurred. This was reversed by another countershock (110V) after a short period of hand pumping. The heart beat then remained stable and the blood pressure was satisfactory.

During the next few days, the patient gradually improved. Mild left heart failure responded to therapy, and he was discharged home five weeks after admission. He continued to take digitalis, quinidine, and a low salt diet.

During the next four years, he remained well and fully mobile. At no time was he in cardiac failure nor did he complain of anginal pain. When seen by his practitioner in January 1964, he had no complaints and was enjoying his retirement. Electrocardiogram revealed evidence of old anterior and posterior myocardial infarction and left ventricular strain. Blood pressure was 130/70 mm. Hg.

On February 27, 1964, while in a taxicab, the patient collapsed without warning. His wife urged the taxi driver to go to the nearest hospital as quickly as possible. She started mouth-to-mouth breathing. Several spontaneous respirations were noted during the three to four minutes it took the taxi to reach the Emergency Room of The University Hospitals. External cardiac massage was started immediately. Oxygen was given first by face mask and then by endotracheal tube. A good carotid pulse was felt as soon as external massage was started. The pupils were initially large and unresponsive to light but quickly came down to normal size. The electrocardiogram showed ventricular fibrillation. Within minutes an intravenous infusion was started and metaraminol given by this route. Three ampules of sodium bicarbonate (3 x 44.4 mEqs) were given intravenously at this time.

The patient was moved to a Beck-Rand machine[1] for external cardiac massage. Systolic blood pressure readings at this time varied from 140 to 170 mm. Hg. After nine external shocks (480 volts, A.C.) the heart remained defibrillated, the last shock being given 28 minutes after the patient was admitted. An arterial blood sample taken 10 minutes later showed the pH to be 7.35, pCO_2 49 mm. Hg, and the CO_2 content 26.7 mEq/liter. The patient was then transferred to the intensive care unit.

During the next 24 hours, his condition slowly improved. Blood pressure was maintained with minimal doses of metaraminol. Urine output was adequate. Electrocardiogram suggested recent anterior myocardial infarction. Procaine amide was given in regular doses because of occasional premature ventricular beats. The patient was wide awake at this time, although confused and irrational.

Over the next few days his cerebral status improved. He had periods of complete lucidity, being able to converse with his wife and cooperate with nursing and medical staff. Because of secretion retention and inability to cough adequately, a tracheostomy was done to permit tracheal suction and assisted ventilation. Postural drainage and antibiotics had been started on the day of admission.

Seventeen days after admission, the patient's condition began to deteriorate. He developed signs of spreading bronchopneumonia and, despite vigorous therapy, died on March 9, 1964, three weeks after his second cardiac arrest.

The immediate cause of death was confluent bronchopneumonia involving most of the left lung. Examination of the coronary vessels showed severe atherosclerosis. There was aneurysmal dilatation of the apex of the left ventricle with scarring of anterior, posterior, and lateral walls. Recent ex-

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From the Western Reserve University, University Hospitals, Cleveland, Ohio.

Submitted November 22, 1965.

tension of the anterior infarct was present. A mural thrombus was found adherent to the underlying endocardium. Pathologic changes were not identified in the brain.

Comment

This is probably the first occasion when successful defibrillation was carried out on two separate occasions on the same patient, with such a long time interval. The fact that the patient was near the hospital at the time of his second attack was undoubtedly important as regards his immediate survival. Despite severe myocardial damage, it is significant that defibrillation was accomplished with restoration of an adequate heart beat.

The complications which followed, rather than any failure of the resuscitation procedure, were the factors which caused this patient's death and serve to emphasize the importance of vigorous and detailed medical care right from the time of arrest. The relatively advanced age of the patient must also have weighed heavily against his long term survival. The heart was severely damaged by old and recent infarcts. In spite of severe damage it was possible to defibrillate the heart and restore a coordinate beat to virtually provide this patient with his third life.

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Letter To The Editor

Perry R. Ayres, M. D., Editor
The Ohio State Medical Journal
Dear Dr. Ayres:

When I discussed my experiences in Paris in my "Medical Travelogue," [*The Journal,* pp. 323-328, April 1966], I erroneously said that the non-identical twin recipient of a transplanted kidney was the longest surviving in the world. The Parisian, of course, has every reason to be happy about the fact that he is now going for so many years. But, to put the record straight there is another non-identical twin transplant which was done by the group in Boston at Peter Bent Brigham Hospital, and whose transplant is approximately six months older than the Parisian's.

I assume that it is well known that the group at the Peter Bent Brigham Hospital are indeed the pioneers of kidney transplantation in man. In that group were Doctors Murray, Merrill, Hume and many others.

The readers will perhaps forgive my error when they realize that it was made in Paris.

Sincerely yours,
W. J. Kolff, M. D., *Head*
Department of Artificial Organs
Cleveland Clinic Foundation
Cleveland, Ohio 44106
July 12, 1966.

SPECIALIZATION IN MEDICINE was inevitable when the horizon of medical knowledge became too broad for the comprehension of one person. As time moves on, this tendency will increase with a continued fractionation of the broad spectrum of medical disciplines. Certainly this changing pattern makes available highly specialized and efficient techniques of medical diagnosis and therapy, but all too frequently, the focus of attention narrows upon a *fragment* of the whole person. No one bemoans the passing of the horse and buggy doctor with his well-intentioned but far too often inadequate therapeutic and prophylactic efforts, and yet, this dignified and respected man of medicine dispensed a compassion of human understanding so essential to the healing of the whole body. Too often today we find this compassion lacking in the technically efficient but impersonal mechanics of modern medicine. — Melvin A. Casberg, M. D., Long Beach, (From an address at the installation of Granger E. Westberg as the first Dean of the Institute of Religion, Texas Medical Center, Houston, Texas, April 2, 1965), *California Medicine,* 104:381-386, May 1966.

The Runaway Artificial Pacemaker

Report of a Case

HERMAN K. HELLERSTEIN, M. D., TOM R. HORNSTEN, M. D.,
and JAY L. ANKENEY, M. D.

THE advent of the artificial internal cardiac pacemaker[1] is but one of the myriad of examples of the modern application of electronic engineering to clinical medicine. The use of this instrument now permits previously incapacitated patients with refractory heart block to lead relatively normal lives. In the early years of the use of artificial pacemaking devices, major difficulties were encountered. Better engineering has since eliminated or at least anticipated many of these difficulties, but some problems still remain. Some of the difficulties which have developed in one patient are illustrated by the case presented below.

Case Report

This 38 year old white woman was admitted to University Hospitals of Cleveland for the 11th time on May 13, 1962, with the chief complaint, "My pacemaker isn't working." This patient had been in her usual state of good health until 1954 when, six weeks postpartum, she first developed syncopal attacks. In July, 1956, convulsions occurred concomitant with syncope, and the patient's physician referred her to University Hospitals of Cleveland for further study. During the next four years she was hospitalized on 10 occasions because of syncopal episodes concomitant with complete heart block and recurrent ventricular asystole. Various modes of therapy were instituted but were unsuccessful, viz, Isuprel®, ephedrine, atropine, Thorazine®, salt restriction, prednisone, deep sleep therapy, and bilateral vagotomy. In October, 1960 the patient was admitted to another medical center for study and treatment. During seven months hospitalization, studies were singularly negative and an internal electrical pacemaker was implanted in three stages on December 15, 1960, April 18, 1961, and May 12, 1961.

The patient was asymptomatic until November, 1961, when the electrical pacemaker ceased functioning. She returned to the same medical center where the pacemaker had been implanted. It was found that a soldered joint connecting an electrode wire to the lead from the pacemaker had come apart and that the insulating plastic covering the junction had leaked. The connection was re-established and the pacemaker resumed control of the heart beat.

For the following six months, there were no syncopal episodes. However, on Sunday morning, May 13, 1962, the patient noted the sudden onset of tachycardia, which was accompanied by nausea, vomiting, and dyspnea. She was transported 125 miles by ambulance and was admitted to the University Hospitals of Cleveland. The temperature was 37.4 degrees C.; pulse rate, 190; blood pressure, 80/50 mm Hg. The neck veins were distended to the angle of the jaw, when the patient was in a semi-Fowler's position. The left border of cardiac dullness was in the anterior axillary line in the fifth intercostal space. All peripheral pulses were poorly palpable. She was in circulatory failure.

The electrocardiogram revealed a heart rate of 190 corresponding to the electrical pacemaker stimulation (Fig. 1). It was thought that the batteries driving the patient's electrical pacemaker mechanism were failing, and as a result, the timing mechanism was causing the pacemaker to increase in rate. The patient presented a most difficult therapeutic problem, and one for which we were unprepared at the time (1962). We possessed neither definite information as to the exact type of the pacemaker nor wiring circuits of the most commonly used pacemakers. She did not possess a wiring diagram describing the circuitry of the pacemaker mechanism, and a case such as hers had not been encountered previously. This was the first documented case of ventricular tachycardia due to failure of an artificial pacemaker with 1:1 conduction. One of us (HKH) later learned of a case of battery failure resulting in 2:1 conduction, but we were not aware of this incident at that time. In fact, we had been favorably impressed by the reported success of the application of pacemakers. An advertisement of one company manufacturing a pacemaker had stated: "Three million transistor hours have been accumulated in patients without a single failure."[2]

With a sense of urgency, steps were taken to solve this problem.* In general, the object was to disconnect the intracardiac electrodes from the internal electrical pacemaker and to connect them instead to an external stimulating device. The possibility of the need for such an emergency transfer had been considered by most manufacturers of pacemakers. The runaway device was equipped with a safety extension or "pigtail" which contained circuitry

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Supported in part by a grant from the Harry Sacks Memorial Fund.

*We are indebted to the interns, nurses, orderlies, x-ray technicians, and telephone operators whose services were so willing and capably mobilized.

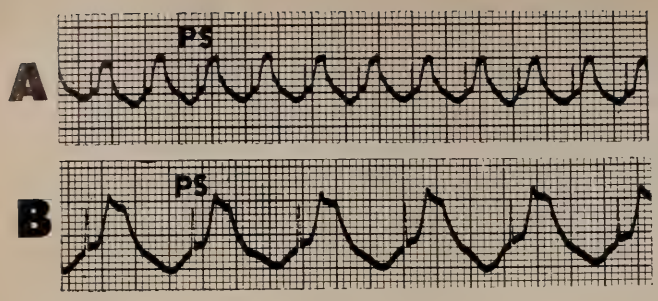


FIG. 1. *Ventricular tachycardia due to failure of implanted artificial pacemaker, with 1:1 conduction at a rate of 190 per minute. Electrocardiogram on admission to the University Hospitals of Cleveland.* (ROW A): *Lead aVR, paper speed 25 millimeters per second, standardized 1 millivolt = 10 millimeters deflection. Note 1 millisecond pacemaker signal* (P. S.) *preceding each QRS complex.* (ROW B): *Lead aVR, paper speed 50 millimeters per second, standardized 1 millivolt = 10 millimeters deflection.*

through which the pacemaker might be "shorted out" and an external stimulator attached. The first step was to locate the pigtail. It was easily palpable in its subcutaneous position. An emergency x-ray confirmed the exact location of the pigtail (Fig. 2). Once the pigtail was located, however , the most important question still remained, ie, exactly what to do with it.

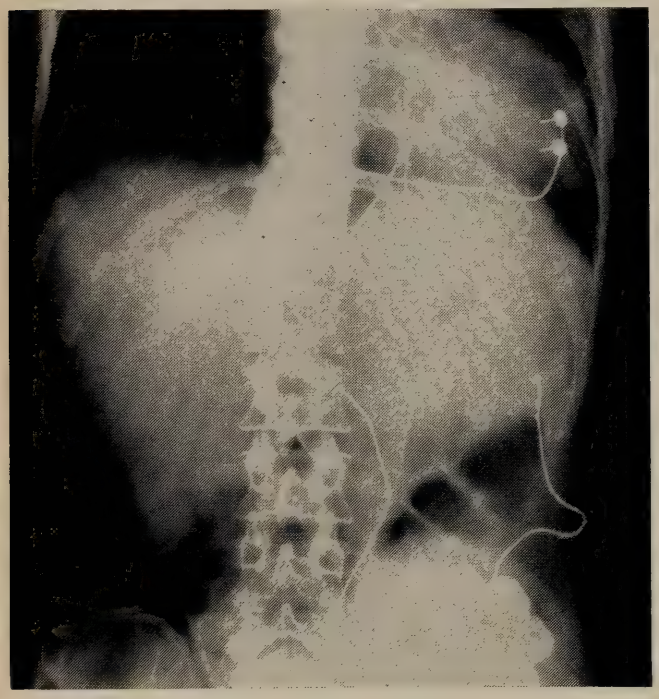


FIG. 2. *Roentgenogram showing bipolar patch electrodes in left ventricular wall, pigtail in subcutaneous tissue of left abdominal wall, and subcutaneously implanted pacemaker, (at the lower right corner).*

Emergency telephone calls to three widely dispersed cities were made on this late Sunday afternoon: (1) to the other medical center which kindly scoured the neighboring suburban areas to locate the surgeon who had implanted the pacemaker and who identified for us the manufacturer and provided details of the implantation of the pacemaker; (2) to the manufacturing company; and (3) to Dr. William Chardack at Buffalo, New York, the surgeon whose extensive experience and leadership in the field of pacemaking devices is widely recognized. We were informed that within the pigtail there were three wires, two of which were connected to the opposite ends of a resistor. One wire attached to the resistor was to be cut and an external stimulator was to be introduced into the circuit through connection with the cut wire and the third wire.

Equipped with this knowledge we were ready to proceed. The following events transpired in the patient's hospital room. An electrocardiographic monitor was connected to the patient's chest so that the electrical complexes would be visualized. Employing local anesthesia, one of us (J. A.) externalized and opened the pacemaker pigtail. It was found to contain three extremely fragile wires as described, but there was no color code or other type of coding to indicate which end of the resistor was at the higher potential. Although this information was described in the manufacturer's instructions, these invaluable data were not available to us at the time and it was necessary to know these facts if the wire were to be cut in the proper place. A voltmeter was needed post-haste. Therefore, an emergency triple page was put out summoning the hospital electrician who, blue clad and equipped with his voltmeter, attempted to ascertain which end of the resistor was at the higher potential.

A decision concerning the circuitry was made, a wire was cut, and two wires were attached to an external stimulator.† To the relief of all, the patient's heart contracted in response to the new stimulus (Fig. 3). However, after the first

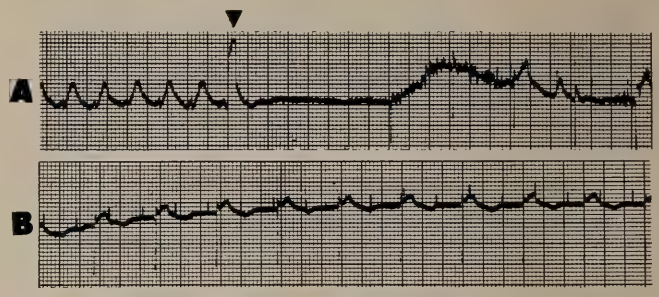


FIG. 3. (ROW A): *Ventricular tachycardia due to runaway pacemaker ceases abruptly when pigtail wire was severed* (arrow). *Ventricular asystole and somatic tremors due to seizure develop in the subsequent 2.6 seconds before the external stimulator was adjusted.* (ROW B): *Immediately after the above adjustment, negative pips of external stimulator are followed by ventricular responses. Positive pips of internal pacemaker continue to occur. See Fig. 4 for explanation.*

sighs of relief, it was noted that, although the heart was responding to the new stimulator, the internal pacemaker was still firing off impulses to which the heart did not respond. The resultant electrocardiogram produced a record of dissociation with "block" between two artificial pacemakers (Fig. 4). Although this was an interesting electrocardiographic phenomenon, it did not appear to be signifi-

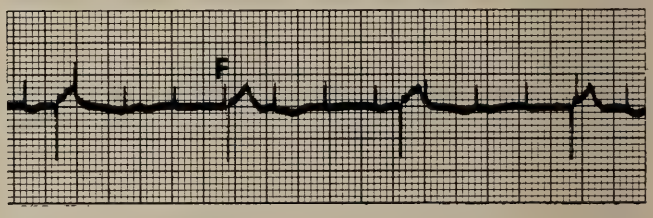


FIG. 4. *Electrocardiogram showing dissociation with "block" between two artificial pacemakers. The positive pips (of the subcutaneous runaway pacemaker) have a rate of 190 per minute and do not influence the basic ventricular rate of 55 produced by the external pacemaker. The failure of the internal pacemaker to capture control of the heart is interpreted to be due either to "block" at the site of myocardial electrode(s) or to inadequate strength of the stimulating signal secondary to battery failure. In either instance, the dissociation between the two artificial pacemakers is due to the equivalent of block and not of interference. There is a third pacemaker, the patient's own pacemaker, which is subservient to the external pacemaker but still capable of independent oscillation (See Fig. 6). Note fusion of the pips of the internal and external pacemakers* (F).

†It is now recognized that there is a potential hazard associated with connecting a line powered pacemaker-monitor to a direct myocardial electrode. Ventricular fibrillation may be produced if the patient is not properly grounded. For this reason line powered pacemaker-monitors should never be used in such circumstances.3

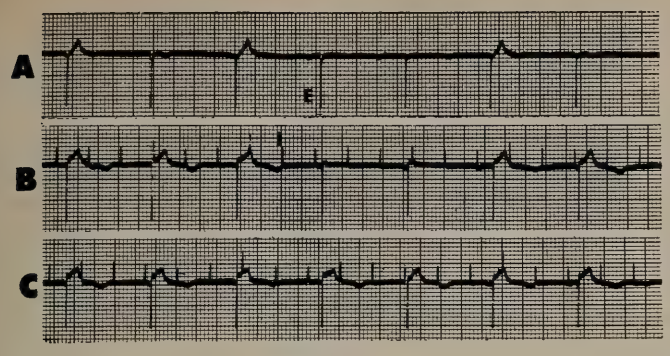


FIG. 5. (ROW A): *Effects of drying of electrode jelly of chest electrode. Some of the stimuli of the external pacemaker* (E) *do not produce a ventricular response.* (ROW B): *As the electrode jelly is replaced, amplitude of the pips of the internal pacemaker* (I) increases. (ROW C): *After the electrode jelly is completely replaced, impulses from external stimulator are all followed by ventricular responses.*

cant clinically. The patient felt well and was responding well to the new stimulation.

As the hours progressed, however, a strange phenomenon began to occur. It was noted that the signal of the external stimulator was not always followed by a ventricular response (Fig. 5), and the voltage had to be augmented steadily in order to provide enough stimulation for 1:1 myocardial contraction. At the sixth hour, 40 volts were required. It was not thought likely that this situation was due to recent polarization of the implanted cardiac electrodes. The cause was not immediately understood. A major crisis developed, however, when an attempt was made to change the position of the electrocardiographic monitor electrodes on the patient's chest to avoid local skin irritation. When the electrodes were removed from the patient's chest wall or when the patient cable was disconnected from the monitor, asystole developed. Furthermore, when the external pacemaker was disconnected, the internal pacemaker also ceased functioning suggesting that the latter was firing through the former (Fig. 6). It was evident that

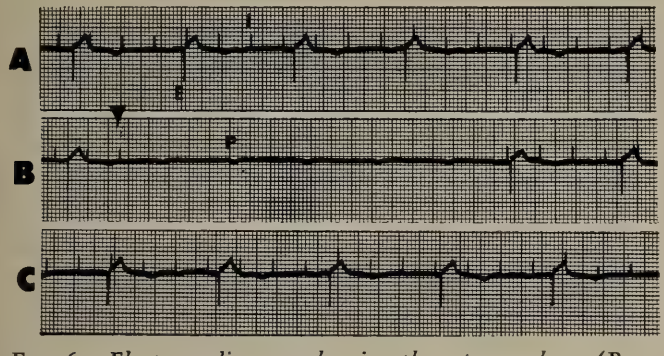


FIG. 6. *Electrocardiogram showing three pacemakers.* (ROW A): *External pacemaker pips* (down, E) *control the ventricles. Internal pacemaker pips* (up, I) *are blocked.* (ROW B): *When the external stimulator was disconnected* (arrow) *both internal and external pips disappear indicating that the internal pacemaker was firing through the external stimulator. The patient's physiologic pacemaker, ie, the sino-atrial impulse* (P) *is blocked at the A-V node.* (ROW C): *The external pacemaker is reconnected and resumes control of the ventricles.*

the external stimulator was not connected properly and that it was attached to the wrong end of the cut pigtail wire.

In some strange way, the circuit was not being completed through the internal wiring but rather through the chest wall electrodes from the monitoring device. The electrode jelly was drying out, and the resistance of the circuit was increasing with the result that more voltage was necessary if an adequate amount of current was to be maintained. It was noted that the amplitude of the signal of the internal pacemaker decreased as the electrode jelly dried and increased when it was replaced (Fig. 5). (Later examination of the pigtail by Dr. William Chardack revealed that one of the wires in the pigtail was broken, and this factor probably contributed to the failure of the circuit to function in a proper manner.)[4] Once the situation was at least partially understood, the stimulator was re-attached to the other pigtail wires. After this procedure was performed, the internal pacemaker ceased oscillation, and the heart responded to the external pacemaker stimulus (Fig. 7). It was no longer necessary to increase the stimulator voltage,

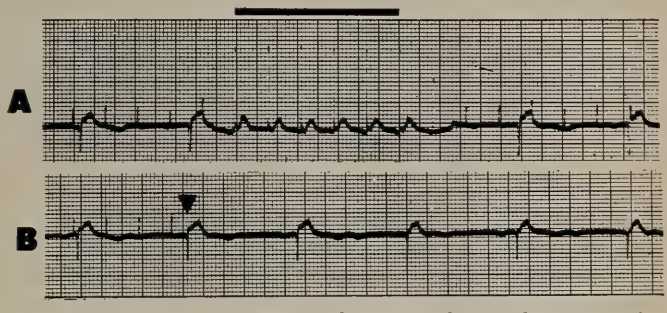


FIG. 7. (ROW A): *When the external stimulator was detached from the indifferent wire,* (black bar) *ventricular tachycardia of the implanted pacemaker* temporarily returned. *Note the increase in the amplitude of the signal of the internal pacemaker.* (ROW B): *When the external stimulator was attached to the other end of the severed pigtail wire* (arrow), *the internal pacemaker ceased firing and the heart responded to the external pacemaker only.*

and the monitor electrodes could be removed without danger of asystole.

On May 16, 1962, a new internal pacemaker was inserted. The patient had occasional extrasystoles during the immediate postoperative period, but following this she was asymptomatic with a heart rate of 64. She was discharged May 26, 1962, with the diagnosis, "dysfunction of an artificial cardiac pacemaker."

The patient did well until December 22, 1962, at which time she noted "irregularities" in her heart beat. Upon admission to the hospital, electrocardiographic tracings revealed a regular pacemaker rate of 62, but there were frequent beats during which the pacemaker failed to stimulate the ventricles. It was thought that the difficulty lay in the end plates of the electrodes implanted within the myocardium. The whole unit, including both pacemaker and electrodes was replaced, and regular rhythm was restored.

The patient again continued to be asymptomatic until June 18, 1964, when she developed an episode of syncope. She suffered five other syncopal attacks that day and again reported to the hospital. This time electrocardiograms revealed a pacemaker rate of 71, but there were occasional episodes during which the pacemaker failed to fire once or even twice in succession, causing periods of asystole. Failure of the timing circuit was considered to be the cause of this most recent pacemaker dysfunction, and when the pacemaker unit was replaced, the patient experienced no further discomfort.

Discussion

Although the production of an electrocardiogram such as the one described, revealing dissociation between two artificial pacemakers, may border on the humorous, the situation which is illustrated by the above case report is serious indeed. An electronic instrument responsible for a patient's life had failed five times. A soldered connection had once come apart; a pigtail wire had broken; and the batteries, timing circuit, and end plates each had failed. One to one conduction with life threatening ventricular tachycardia had developed.

The probability of occurrence of many of these types of failure has decreased since 1962 because of

better technical features in pacemakers now being implanted. Two of the failures in the above described case were due to breakdown of the electrodes, which were of inferior quality and had not been constructed by the company which had manufactured the pacemaker mechanism. Chardack[5, 6] reports that the platinum coil electrode has virtually terminated the problem of myocardial electrode failure. Changes in the design of the safety pigtail have minimized breakage of these extension wires. The problem of the fast failure of a runaway pacemaker[7, 8] has also been alleviated.

The original fear with the use of internal pacemakers was that there would occur a rise in threshold current requirements secondary to increasing fibrosis around the implanted electrodes. Because of this concern, the original pacemakers were constructed with 10 battery cells capable of putting out a high current. Only a few of these battery cells also contributed to the timing circuit of the pacemaker. Originally, with a 10 cell unit, it was thought that the failure of one cell in the timing circuit would produce an increase of 15 per cent in the heart rate. Should a second battery fail, the pacemaker rate would again increase, but the total output would then have dropped to below threshold levels, thus preventing a 1:1 response. However, it was found that increasing current thresholds tended not to occur and that as a result, although a cell in the timing circuit might fail, the remaining cells would still provide enough output to drive the heart at a higher rate.[6] Chardack's 12 cases of pacemaker failure secondary to battery depletion in 60 patients with pacemakers were all in units with 10 cells constructed as above.[6]

The pacemaker design was therefore changed so that only five or six battery cells are present, all of which drive both timing and output circuits. Loss of up to three cells is estimated by Chardack to have "very little" influence on the heart rate and loss of a fourth cell would produce only a 10 per cent increase in rate. However, by this time the output of the unit will be below the myocardial threshold to stimulation and fast failure will not occur.[6] Rather, the heart will revert back to its previous state of complete A-V block. Chardack reported no failures secondary to battery depletion in 17 patients with this improved circuitry between April, 1962 and August, 1963.[6]

Although newer technology is helping to solve pacemaker problems, the threat of pacemaker failure still remains a constant danger. It should be mentioned that sudden return to complete A-V block is in itself dangerous, and immediate death may follow as is illustrated by the following case:

A 78 year old white man with complete heart block underwent implantation of an artificial pacemaker manufactured by the same company that produced the pacemaker involved in the above described case. Three years after implantation, the patient suddenly developed syncope and was brought to University Hospitals of Cleveland, dead on arrival. An electrocardiogram revealed no cardiac activity. An impulse was present in a direct writer electrocardiograph which at first blush appeared to be 60 cycle current. However, this was demonstrated on oscilloscopic and photographic traces as being the discharge of the pacemaker at a somewhat irregular rate between 660 and 900. The pacemaker was removed from the body and output voltage measured. It was only 150 millivolts as compared with a usual output near 8000 millivolts. The manufacturer examined the defective pacemaker and ascribed its premature failure to the failure of the oscillator transistor. The resistance in the collector circuit of the oscillator transistor had increased and caused significant rate changes in the oscillator circuit with secondary rundown of the battery.

Autopsy examination revealed definite fibrosis around the electrodes implanted within the myocardium. It is postulated that with the fast, ineffective (low voltage) discharge of the artificial pacemaker, the patient's heart reverted to its previous state of complete A-V block, whereupon an immediate and fatal Stokes-Adams attack occurred.

Because of the gravity of the threat of pacemaker failure, certain suggestions are proffered for the further safe clinical use of internal pacemaking devices.

1. All Patients with Internal Pacemakers Should Carry Information Describing These Devices with Them at All times. Such information should include x-rays for the location of safety pigtail devices and schematic wiring diagrams for interpretation of the pacemaker circuitry. Without these precautions, the dangers and difficulties involved in attempting to correct pacemaker failure are obviously increased. If necessary, wiring diagrams could be copied on microfilm and actually placed inside the body of the pacemaking device. Such diagrams might also contain references to color codes which should be used on wires, as well as detailed procedures for repair and temporary substitution of malfunctioning pacemaking devices.

2. Adequate Warning of Impending Pacemaker Battery Failure Should Be Available. Changes in the x-ray picture of the battery pack in situ have been shown to reflect the state of its change. However, measures should be available to indicate acute changes. Pacemakers might be equipped with an audio signal, which would produce a warning sound as soon as one battery began to fail. This is especially important since, with the use of pacemakers now being employed, the heart rate may neither increase nor decrease until at least three batteries fail. Patients should be instructed, of course, in the routine taking of pulses periodically during the day so as to note any change in rate. They should be instructed to report to their physicians at the earliest signs of pacemaker failure.

3. An Attempt Should Be Made to Standardize Pacemaker Design and Parts. Today, with many different manufacturers designing and constructing artificial pacemakers, small mechanical differences in parts make it difficult to replace failing pacemaker components. The patient may find it necessary to return *frequently* to the original hospital where a particular replacement part is available. With interchangeability of parts, most pacemaker components could be stocked at major hospitals throughout the

country, and time involved in treating life-threatening situations secondary to pacemaker dysfunction might be minimized.

The runaway pacemaker is an interesting but indeed frightening complication of the application of electronics to clinical medicine. Through both electrical and clinical safeguards, however, its occurence may be minimized.

Summary

A case is reported of artificial pacemaker induced ventricular tachycardia with 1:1 conduction at a rate of 190 beats per minute. Suggestions are proffered for the further safe clinical use of artificial cardiac pacemakers.

Acknowledgment: The authors are indebted to Doctor Robert Rinderknecht, Dover, Ohio for the privilege of studying this patient.

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PACEMAKER PROBLEMS. — Thirty-eight implantable pacemakers have been inserted in 29 patients at the University of Florida Hospital during the past three and one-half years. A total of 15 complications occurred. There are 22 survivors; three of the seven deaths were unrelated to the pacemaker. Two deaths were due to infection as a complication of the insertion of the pacemaker. One death occurred because of unrecognized electrode failure, and one death occurred on the fifth postoperative day, possibly as a result of ventricular fibrillation secondary to competition for ventricular stimulation by the myocardial versus the electronic pacemaker.

Of the 16 patients operated upon in the last 18 months only two have had to be reoperated upon, one because of electrode wire breakage and one because of infection.

Of nine survivors living 18 months or more after the original pacemaker implantation, only four have not had to have operation for replacement of the pulse generator unit. Battery failure can be held accountable for the need for reoperation in three patients and wire problems in two.

On the basis of our experience, we believe that the intravenous right ventricular electrode with an external power source should be used from the time of admission to the hospital until the patient is in optimum condition for operation. In very elderly, feeble or infected patients, the right ventricular electrode with an implanted pulse stimulator seems most desirable at present. For complete heart block the fixed rate pacemaker has been reasonably satisfactory. The atrially activated pacemaker is used in patients with intermittent episodes of complete heart block associated with symptoms of cerebral ischemia.

Wire failure is handled by grounding first one wire and then the other in the subcutaneous tissue. If this fails to achieve a ventricular response, both wires are attached to an external power source. If this fails, a general anesthetic is given and a completely new unit implanted. — Thomas D. Bartley, M. D., and Myron W. Wheat, Jr., M. D., University of Florida, Gainesville: *The Journal of the Florida Medical Association,* 53:498-503, June 1966.

Suprapubic Catheterization

Preliminary Report of a New Postoperative Technic

DONALD W. SHANABROOK, M.D.

URINARY TRACT infection in Obstetrics and Gynecology is a problem of serious proportions and, to date, of partially unknown consequences.[1,2] It is not at all uncommon, especially in the course of pregnancy and gynecologic surgery. Many physicians[3-6] have studied the problem in an effort to elucidate the etiology and pathogenesis of urinary tract infections and in order to prevent acute and chronic urinary problems.

In this study, our primary effort has been to investigate an uncomplicated and practical method of bladder drainage that would prevent or minimize urinary tract infection, with special reference to gynecologic surgery. This method was in part suggested by British authors[7-10] who employed a suprapubic puncture for the relief of acute urinary retention or for bladder drainage. We reasoned this would eliminate the pericatheter route of infection suggested by some physicians as important with indwelling urethral catheterizations.[11]

Methods and Material

Bladder drainage in the postoperative gynecologic patient can be achieved by inserting a 5 FCG (French Catheter Gauge) polyethylene tube into the bladder. The equipment required for this type of drainage is shown in Fig. 1. This is accomplished following the surgical procedure by filling the bladder, via a urethral catheter, with approximately 300 cc. of normal saline to which 1 cc. of methylene blue is added as shown in Fig. 2. Percutaneous puncture of the bladder is made in the midline, 2½ cm. above the symphysis with a 13 gauge 3½ inch needle, and free flow of the blue colored saline signals entrance into the bladder as shown in Fig. 3. At this point, the catheter is inserted through the needle into the bladder. Then, the needle is withdrawn, as shown in Fig. 4. The catheter is connected to an intravenous tubing for constant open drainage, and the polyethylene tube and the first portion of the collecting tube are taped securely to the anterior abdominal wall in order to prevent inadvertent removal of the catheter, as shown in Fig. 5. The methylene blue saline solution is drained through the urethral catheter, which is then removed. An attempt was made to obtain a preoperative and 24 hour post-catheterization urinalysis, culture, and colony count in each case, to evaluate the efficacy of the procedure.

Submitted December 20, 1965.

The Author

● **Dr. Shanabrook, Tiffin, former Resident in Obstetrics and Gynecology, St. Luke's Hospital, Cleveland, presently is staff member, Woman's Clinic, Tiffin, and Associate Staff member, Mercy Hospital in Tiffin.**

Results

The procedure was done in 20 patients, 15 of whom had anterior and posterior colporrhaphy, and usually a vaginal hysterectomy. Total abdominal hysterectomy was done on the remaining five patients. A number of clinical observations became readily apparent almost at the onset of the study. This method of catheterization is without discomfort to the patient. There is no sensation of urgency as is frequently experienced with urethral catheters, and no pain or discomfort were noted on catheter removal. Furthermore, patients were not aware of the presence of the catheter. The catheter maintained constant bladder drainage despite its narrow lumen. Blockage of the catheter was noted on only one occasion, caused by a small blood clot. This was easily removed with normal saline irrigation, without recurrence of the obstruction. Bacteriuria was noted in eight cases, using a baseline of 100,000 bacterial colonies per cc. of urine. However, none of these patients had symptoms of urinary infection. Antibiotic therapy was used in three of these patients, and all eight of these had negative urine cultures three to four days after treatment.

Our original purpose was to develop a method of catheter drainage which would eliminate bacteriuria. This may yet be the case with continued experience with this procedure. We have considered using a somewhat larger catheter to maintain even greater bladder drainage and rest, precluding any increased muscle tension or residual urine in the bladder. The catheter is removed, following spontaneous urination

via the urethra, which usually occurs in four to five days in cases of extensive surgery. Bladder decompression was adequately maintained, and no instances of overdistention were noted, despite the small lumen of the tubing.



FIG. 1. *The equipment required for this procedure is readily available.*

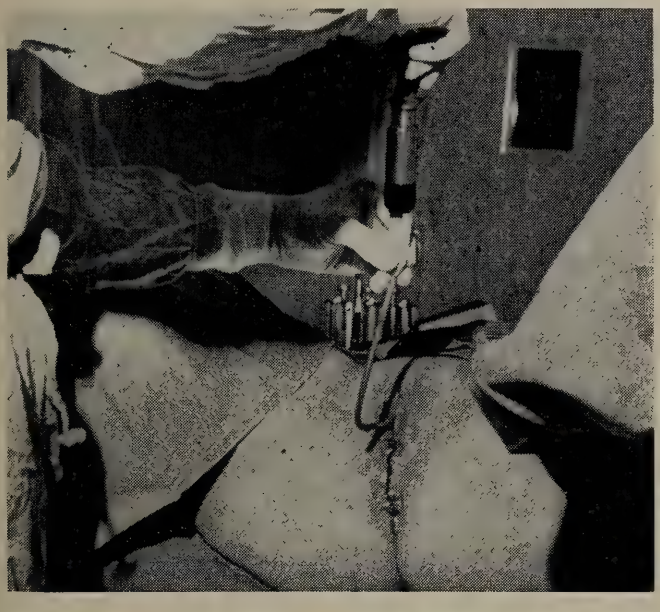


FIG. 2. *A urethral catheter is inserted following the operative procedure and the bladder is filled with 300 cc of normal saline to which 1 cc of methylene blue is added for easy visualization.*



FIG. 3. *A percutaneous puncture of the bladder is made 2½ inches above the symphysis in the midline with a 13 gauge 3½ inch needle, and the free flow of the blue colored saline signals entrance into the bladder.*

Comments

There are many methods available to prevent bacteriuria after gynecologic surgery and catheterization. The use of clean, voided urinary specimens properly obtained and examined, has been demonstrated to be an accurate method of evaluating the urinary tract of the patient without catheterization.[12] Antibiotic ointments can be used for lubrication during urethral catheterization, to reduce bacteriuria.[13,14] Many obstetric and gynecologic procedures can be done without urethral catheterization, or with catheterization for only 24 hours or less; ie, routine deliveries, cesarean sections, abdominal hysterectomy, and adnexal surgery.[15] This can be done without an increase in morbidity from urinary tract infection.

At the present time, it is impossible to prevent all cases of bacteriuria and urinary tract infections, since we are frequently operating in close proximity to a urinary tract which is either infected or has weakened



FIG. 4. *The polyethylene tube is inserted through the needle into the bladder, then the needle is withdrawn, leaving the polyethylene tube in place.*

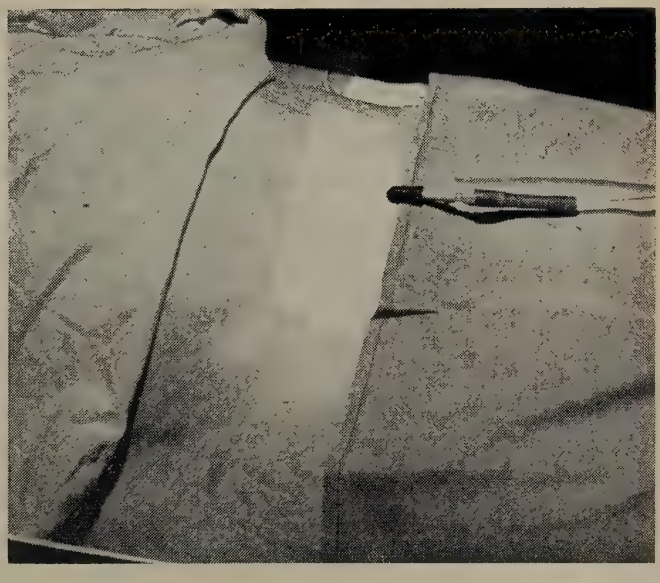


FIG. 5. *The catheter is then connected to a constant drainage system.*

bacteriostatic mechanisms. A recent study by Cox and Hinman[16] has uniquely demonstrated inherent bacteriostatic properties of the bladder. Our aim has been to enhance and protect this mechanism by procedures such as suprapubic catheterization and drainage.

Summary

A new procedure has been presented, which can maintain urinary asepsis and bladder drainage, avoiding urethral catheterization, which almost certainly results in significant bacteriuria after 48 hours. Although this procedure requires more evaluation, it does offer a method of postoperative bladder drainage, which is comfortable for the patient and helpful to the physician, without cumbersome equipment or time consuming procedures.

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HODGKIN'S DISEASE AND LYMPHOSARCOMA. — The cooperation of physicians is requested in a study of Hodgkin's disease and lymphosarcoma being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Particularly desired are patients who have had no previous treatment or minimal prior treatment. All clinical stages of biopsy-proven disease are acceptable. The major purpose of the study is to determine the curative potential of intensive radiotherapy in localized cases and to evaluate combination chemotherapy and x-irradiation in patients with generalized involvement.

Physicians interested in having their patients considered for the study may phone or write to: Paul P. Carbone, M. D., The Clinical Center, National Institutes of Health, Building 10, Room 12-N-228, Bethesda, Maryland 20014; Telephone: 656-4000, Ext. 64251. — ANNOUNCEMENT, Clinical Center, NIH, April 1966.

HYPER- OR HYPOPARATHYROIDISM. — The cooperation of physicians is requested in a study of patients with either hyper- or hypoparathyroidism in conjunction with developing a practicable immunoassay for parathyroid hormone being conducted by the Metabolic Diseases Branch of the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Of interest for this study are patients with kidney stones and/or bone demineralization in association with high serum calcium and/or low serum phosphate. Patients with hypoparathyroidism (congenital or following extensive thyroid surgery) having low blood calcium and high serum phosphorous are also needed.

Physicians interested in having their patients considered for the study may write or telephone: Gerald D. Aurbach, M. D., Clinical Center, Room 9-D-14, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 656-4000, Ext. 65051. — ANNOUNCEMENT, Clinical Center, NIH, April 1966.

Hemophilus Influenza Meningitis

Report of a Case Complicated by Subdural Empyema

C. NORMAN SHEALY, M. D.

SUBDURAL effusions are frequent complications of infant meningitis, which usually resolve with repeated subdural taps. Some of these infants will then develop hydrocephalus as meningeal thickening blocks either the arachnoidal villae or the basilar cisterns. This report concerns an unusual instance of thick empyema following hemophilus influenza meningitis.

Case Report

This 3 month old male child was admitted to University Hospitals October 20, 1963, with a five-day history of fever and lethargy. Past history was not remarkable.

Physical examination: Temperature was 40.4 degrees C (rectal); pulse, 180 per minute; respirations, 48 per minute. The patient was acutely ill and moderately lethargic. Head circumference was 44.2 cm. with a bulging, tense fontanelle. There was generalized decreased muscle tone and poor reactivity. Deep tendon reflexes were hyperactive.

Laboratory Data: Hemoglobin was 9.6 Gm. per 100 ml. and white blood cell count, 17,000 with a shift to the left. Lumbar puncture yielded cloudy fluid with 1000 WBC/cu.mm. and a protein of 28 mg./100 ml. Cultures grew *Hemophilus influenzae.*

Hospital Course: The patient was begun on treatment with penicillin, Chloromycetin® and Gantrisin®. He improved somewhat but continued to spike a fever. Six days after admission neurosurgical consultation was obtained, and bilateral subdural taps yielded thick, grossly purulent material. Twenty cc. of this material was withdrawn from each side without total evacuation. Cultures were sterile, and repeated taps yielded similar results. Consequently, on October 29, 1963, large bilateral frontal craniectomies were performed. A small amount of subdural liquid pus was found bilaterally. In addition, there was a thick collection of semi-inspissated pus (Fig. 1), having the consistency of mayonnaise. This extended from frontal tip to midparietal area and across the Sylvian fissures; it ranged from 1 to 4 cm. in thickness. In some areas small to moderate blood vessels floated on the surface of the gelatinous, suggesting that portions were subarachnoid. In fact, it was impossible to distinguish subarachnoid from subdural space. The pus was removed by suction and debridement and the bone flaps were left out. Cultures remained sterile.

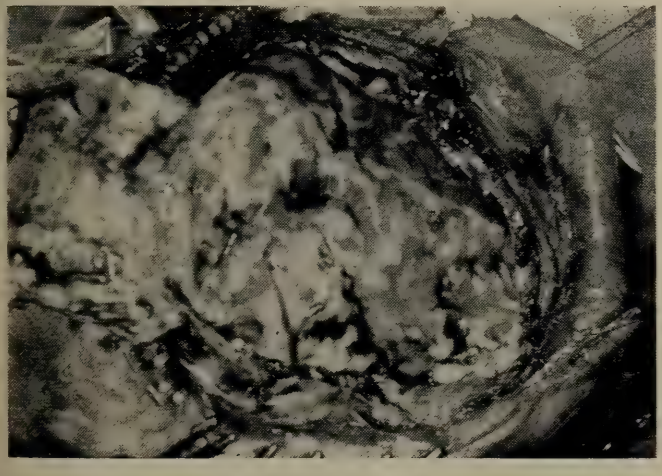


FIG. 1. *The left frontal area showing extensive collection of subdural and subarachnoid pus.*

Postoperatively the patient did exceedingly well and remained afebrile. Antibiotics were continued for three weeks. Two weeks after surgery, however, the craniectomy sites remained slightly tense. A ventriculogram revealed moderate communicating hydrocephalus. On November 19, 1963, a lumbar subarachnoid peritoneal shunt was done with immediate softening of the decompression sites. Two months later the shunt blocked and a ventriculojugular shunt was done without incident. The child continues to develop normally, walked at 1 year of age, and seems bright. The right craniectomy site has ossified and the left has almost closed.

Discussion

From 30 to 50 per cent of infants with influenza meningitis develop subdural effusions.[1] In no recent article or textbook has post-meningitis subdural empyema been reported. Dandy mentions subarachnoid abscess as one of many complications of meningitis,[2] but no case report has been located.

It seems unlikely that the thick pus found at surgery would have reabsorbed without considerable scarring; furthermore, despite the fact that no organisms were grown from the pus, fever continued until surgical drainage. Undoubtedly development of such pus is a rare occurrence since the advent of antibiotics, which were successful in halting the progress of the meningitis but apparently did not prevent progressive formation of pus. It is not surprising that hydrocephalus would develop in such a situation.

Summary

This is the first known case report of a 1 to 4 cm. thick inspissated subdural and/or subarachnoid empyema developing from hemophilus influenza meningitis.

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2. Dandy, Walter: "The Brain," in Lewis, Deal (ed.): *Practice of Surgery,* Hagerstown, Md.: W. F. Prior Company, 1932, pp. 354-355.

From the Division of Neurosurgery, Western Reserve University School of Medicine and University Hospitals, Cleveland, Ohio.

Submitted December 22, 1965.

The Author

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A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

Presented by

- William E. Hunt, M. D., Columbus, and
- Leopold Liss, M. D., Columbus;

Edited by Dr. Liss.

PRESENTATION OF CASE

First Admission: This white male barber, aged 46, was well until approximately one year prior to his first admission to Ohio State University Hospital. At that time he noted reddening and inflammation of his left eye. The inflammation cleared spontaneously except for an occasional light spot that appeared in the central vision of the left eye and was episodic in nature. After an examination by an optometrist, the patient received glasses. He was then symptom-free until four weeks prior to the admission when he noted a rapid decrease in the visual acuity of the left eye and mild left frontotemporal headache. The visual acuity worsened over the next two weeks until he had complete loss of vision in the left eye.

On admission to the hospital the physical examination revealed blindness in the left eye. The left pupil did not react to light but reacted to accommodation, and the left optic disk appeared slightly paler than the right. The skin over his entire body was moderately dry and scaly. The physical findings were otherwise normal.

The admission laboratory studies, which included urinalysis, blood urea nitrogen (BUN), fasting blood sugar, blood count, and serologic tests for syphilis, as well as the electrocardiogram, were reported as within normal limits. The chest x-ray was not remarkable. Skull x-rays showed suggestive erosion of one anterior clinoid. The optic foramina and paranasal sinuses were normal. The electroencephalogram was abnormal with 5-6 second slowing over the left temporal, frontal and central areas. The spinal fluid showed two red cells, no white cells, protein 86 mg., sugar 50 mg., and chlorides 730 mg. per 100 ml. The opening pressure was 270 mm. and the closing pressure 190 mm.

A left carotid angiogram on the fifth hospital day showed some elevation of the middle cerebral artery and its ascending frontoparietal branch with a shift of the anterior cerebral artery toward the right. There was some elevation of the proximal portion of the anterior cerebral artery. A right transbrachial carotid-vertebral angiogram also showed a shift of the anterior cerebral artery to the right, elevation and posterior displacement of the first portion of the anterior cerebral artery. A pneumoencephalogram done at the same time showed a mass lesion of the left side bulging into the third ventricle. Spinal fluid from the pneumoencephalogram showed 1 red cell, 3 white cells, 74 mg. of protein, and 52 mg. of sugar.

On the 15th hospital day the patient underwent a left frontotemporal craniotomy with exploration. A dense arachnoid reaction was found at the base of the brain, around the optic chiasm and optic nerves. The left optic nerve was enlarged to four or five times the size of the right. No mass was found. The left carotid artery was closely adhered to the optic nerve in what appeared to be an inflammatory reaction. The inferior surface of the frontal lobe was also densely adherent to the optic nerve and chiasm on the left. Biopsy of the arachnoid was done. Because of the possibility of inflammatory disease, biopsy of the optic nerve was not performed.

Postoperatively the patient recuperated fairly well. The visual fields continued to show blindness in the left eye and a temporal hemianopsia in the right eye. The postoperative period was complicated by urinary infection which responded quite well to appropriate antibiotic therapy. He was discharged after six weeks in the hospital.

Second Admission

The patient was readmitted approximately one month after his discharge. He had done poorly and had become progressively confused and lethargic. The blindness continued and increasingly progressive right-sided weakness was noted.

Examination at this time showed a lethargic, stuporous patient who was unable to communicate. He

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had a right central facial paralysis and a right hemiparesis. The right fundus showed papilledema with flame-shaped hemorrhages surrounding the optic disk. No papilledema was noted on the left.

The admission laboratory work showed a hemoglobin of 15.1 Gm., hematocrit 45 per cent, leukocytes 25,500 with 89 per cent neutrophils. The BUN was 10 mg. per 100 ml. The urine was not remarkable.

A left carotid angiogram showed a marked shift of the anterior cerebral artery to the right. A definite tumor was noted in the area of the hypothalamus. The patient became gradually unresponsive and died on his fourth hospital day.

CLINICAL DISCUSSION

DR. HUNT: We are presented with a middle-aged barber who was well until about a year prior to his first admission to the hospital, at which time he had noticed redness and inflammation of the left eye. He was treated with glasses. The inflammation cleared, the protocol states, spontaneously, except for an occasional light spot which appeared in the central vision of the left eye and was episodic in nature. So we are talking in two different contexts: one is the signs of inflammation in the globe and the other is the sign of impairment of vision, and these are of greatly differing significance. In fact, as the history develops, I would almost be inclined to say that the redness and inflammation of the eye had nothing whatever to do with the case. However, we should keep in mind the possibility that the subsequent events here may have been the result of inflammation. If they were, this inflammation involved the eye as well as the intracranial contents, because of subsequent fatal brain involvement. So we have to keep in mind the differential diagnosis of inflammatory disorders.

Progressive Unilateral Blindness

In any event, these things happened to him a year prior to admission, and then he did quite well until about four weeks prior to admission when he rapidly started to become blind in the left eye, and you wonder if this is a natural extension of this inflammatory condition or whether something new is happening. He had a little left-sided frontotemporal headache. This is of considerable importance because headache comes from a limited number of sources, such as traction or dilatation of blood vessels, or inflammation of blood vessels or meninges in locations where sensory fibers are passing through the dura. The concept of inflammation includes blood in the subarachnoid space as well as infections and periarteritic and collagen-like disorders, and mechanical distortion. The degenerative diseases of the nervous system that make one blind, such as multiple sclerosis, are ordinarily not painful.

The patient went rather rapidly blind in the left eye. On examination the left pupil did not react to light. The reaction to accommodation meant that the fibers of the efferent side of the reflex that constrict the pupil were intact, because it could be fixed by accommodation but not by light. There was moderate dryness and scaliness of the skin covering his entire body. It makes us think of neuro-endocrine disturbances. We are already thinking about intracranial lesions that involve the optic nerve, which is in the vicinity of the chiasm and the pituitary. So there is a natural chain reaction in the neurologist's thinking. When he sees somebody coming in with blindness he gets interested in his potency, his skin, what her menstrual period is like, and the weight change and the urinary patterns. You never think of the chiasm without thinking of the endocrine system.

So we proceed then to his admission laboratory work, and his urine, BUN, fasting blood sugar, hemoglobin, hematocrit, leukocyte count, and serology were all normal, as were his electrocardiogram and his chest x-ray. Any time you think of intracranial disease you think of the chest since many intracranial disorders spread from the chest. I don't know whether or not the pituitary was involved. I *do* know that the optic nerve on the left side was involved in some pathological process behind the globe which did not interfere with the flow of its parasympathetic and sympathetic fibers to the globe.

The skull x-rays showed suggestive erosion of one anterior clinoid; this is not firm enough for conclusions. The optic foramina, however, were not enlarged and this tells me that there was no tumor within the substance of the optic nerve inside the optic foramen. There was no tumor within the substance of the optic nerve inside the orbit since no description of proptosis was made. Therefore, if the process was neoplastic, it was intracranial, and if it was inflammatory, it was along the course of the optic nerve, and it is unlikely to have been degenerative because there was pain. Of course, as we read on, the course looks very much like a neoplasm or some savage, inexorable inflammatory process.

Frontal Lobe Lesion?

Then we get our first "curve" here. Here was a man who was normal except for his optic nerve, but we find that there was a 5-6 second slowing over the left temporofrontal and central areas, and this makes you take notice immediately. Are we dealing with secondary involvement of the optic nerve by a lesion in the silent frontal lobes of the brain? Lumbar puncture was done and he had increased intracranial pressure, if this recording is correct. It doesn't specify whether the patient was sitting or lying down, whether or not he was properly relaxed. It is possible that the examiner may have been paying too little attention to some of the things that will give you a false high.

Let's say that this means something, and when I find in addition a protein of 86 mg. in an otherwise normal spinal fluid I am taking very sharp notice of

what's going on. It means that he had organic disease of the nervous system. Elevated protein occurs also in myxedema and this feeds us back to the dry, scaly skin. Also the breakdown of the blood-brain barrier in inflammatory disease and in neoplastic disease will let plasma protein find its way in increased amounts into the spinal fluid. We know then that we are not dealing with any neat, encapsulated lesion like a pituitary adenoma or a craniopharyngioma or an optic nerve glioma. Whatever this was was big enough, inflammatory enough, necrotic enough, producing stasis, degeneration, to cause increase in CSF pressure, an EEG focus, and elevated protein. None of these would happen in retrobulbar neuritis that involves the optic nerve on one side.

When he was hospitalized, he was subjected to angiography and they found evidence of a mass, which confirms our original presumptions here. Pneumoencephalogram also showed a mass bulging into the third ventricle. The elevated protein was confirmed, and he was subsequently subjected to craniotomy, exploration, and biopsy. May we see the x-rays at this point?

Discussion of X-Ray Findings

DR. DUNBAR: In the initial lateral skull film the paranasal sinuses appeared normal. There is some erosion of the anterior clinoid, which is not a firm, solid diagnosis when the sella itself is normal, and the posterior clinoids don't show any evidence of demineralization. In the initial left carotid arteriogram the a.-p. projection shows slight pulling of the anterior from left to right and slight elevation of the initial part of the anterior cerebral. The middle cerebral on this projection is essentially normal.

DR. HUNT: I would call that a little more than slight, just in the interests of future discussion, because ordinarily the anterior communicating lies on the level of the bifurcation of the internal carotid, doesn't it?

DR. DUNBAR: Yes, I don't think there is any question that the elevation is definite.

DR. HUNT: So we've got some mass on both sides of the artery.

DR. DUNBAR: There is a mass both under the initial portion and also on the left side. The lateral view shows an elevated portion of the anterior cerebral artery and a hint of elevation of the middle group. I will go back to the initial arteriogram and show that the mass above the sella is the major concrete finding on this initial arteriogram. On pneumoencephalography in the occipital projection the filling of the ventricle is not good, but this is most likely the anterior third ventricle, shifted from left to right, and there probably is evidence of a mass lesion projecting back of the suprasellar area and displacing the anterior third ventricle from left to right. From these initial studies I would have to say that there was evidence of a suprasellar mass, but I would be unsure of the temporal component — whether there was a mass beneath the middle cerebral artery or not.

DR. HUNT: Is this mass entirely extracerebral or is it intracerebral?

DR. DUNBAR: Such an extensive lesion, going back along the third ventricle, would make me feel that it was within the brain probably.

DR. HAMWI: Do you see any pineal calcifications?

DR. DUNBAR: No, and also no definite shift.

DR. HUNT: The critical points Dr. Dunbar has touched on indicate that there was a mass. Many of the benign lesions, like suprasellar adenomas, don't elevate the protein, don't increase intracranial pressure, don't produce electroencephalographic foci, but will elevate the anterior cerebral just as this mass did. But this mass also shifted the anterior across the midline and it also produced a bend in the third ventricle that suggests, as Dr. Dunbar pointed out, that this may have a significant intracerebral component.

An extracerebral exploration was done first. The left optic nerve was said to have been enlarged. "No mass was found." This is the statement of the protocol. I would have to say that an optic nerve four to five times the size of a normal optic nerve is a mass. This is too big for about anything I know of but tumor. I am sure this refers to the fact that no *other* mass was found. There obviously also was inflammatory reaction, possibly secondary to neoplasia. The arachnoid was biopsied. The patient recuperated. I presume we will be told what the biopsy showed.

DR. LISS: The submitted specimen of arachnoid from the optic nerve and from the frontal lobe showed reactive fibrosis and no neoplastic elements.

DR. HUNT: Very good. Postoperatively, he had a minor urinary infection. He developed some new visual field loss but recuperated fairly well. When he was admitted again, a month after his first discharge, he had done poorly; he showed progressive confusion and lethargy, the blindness continued, and he started to get weak on the right side. So here was a man who was showing progressive damage to his left cerebral hemisphere with hemiparesis, confusion, lethargy, and drowsiness. Are we missing a major endocrine disorder to account for his lethargy, etc? Probably not, because he had a progressive focal neurological sign referable to the area of the brain that we have already been looking at closely.

What sorts of inflammatory disease have this inexorable steady progression? Really none that I know of. The arteritic phenomena look like vascular syndromes, but they can also be excluded. An occasional parasitic infestation? When I'm looking for something unlikely to bring up in the presence of an intracerebral mass I think of a case of schistosomiasis of the brain in a man who had been swimming in

fresh water in Leyte, but I don't expect that to crop up more times in my life. So I think it unlikely that we have a case for inflammatory disease.

So he was lethargic, stuporous, and he had papilledema. His increased pressure had progressed. He had a right hemiparesis, and on the left side he had no choked disk or optic atrophy. This is the Foster Kennedy syndrome, which is supposed to be a sign of tumor that compresses one optic nerve and produces increased intracranial pressure that chokes the other optic nerve. This confirms my impression that we are dealing with a brain tumor. The carotid arteriogram shows that he had a tumor as predicted.

Four Brain Tumors

I would like to emphasize that the neurosurgeon thinks of there being four brain tumors: neoplasm, hematoma, abscess, and brain swelling from whatever cause. Now this patient had a tumor, and since he had a "definite tumor in the area of," I wonder if they mean that they saw a vascular stain that makes it neoplasm, or do they simply mean that they found an extension of what we thought was a mass in the first place? If there was no tumor stain, with this progression, I would rule out tumor due to brain swelling alone. I would rule out hematoma because of onset and progression. I would think that abscess was a distinct possibility because of the inflammatory reaction, and I would think avascular neoplasm, purely for statistical reasons, was the most likely diagnosis. And if there was a tumor stain, a vascular stain, I would say vascular neoplasm. Obviously, a vascular neoplasm in the context that I am using the word is not any basic classification.

DR. DUNBAR: In the left carotid arteriogram the displacement from left to right is greatly increased over the previous examination. The elevation of the proximal portion of the anterior cerebral retains its relatively normal course. The mass lies between the anterior and middle cerebral arteries. The lateral projection shows markedly abnormal vascularity throughout a very large area. It demonstrates clearly a large malignant neoplastic stain throughout this region. The malignant lesion is both suprasellar and deep in the thalamic and the junction of the temporal and frontal lobe areas. I presume it's a cerebral tumor such as a glioblastoma. From the stain it looks a little like meningioma. It is rather homogeneous and fleshy and must have stayed there for a long period of time.

Diagnostic Criteria

DR. HUNT: Thank you, Dr. Dunbar. Then we are down to a vascular neoplasm. The question of malignancy, however, remains with us. The criteria for the diagnosis of brain tumor are based upon the rate of filling of the capillary bed of the tumor, the rate of emptying, how early the veins appear, what the pattern of the vascular change is, and what the relationship of surrounding vessels is that may tell you that this mass was intracerebral or extracerebral. On purely statistical grounds glioblastoma multiforme is the commonest, although of course there are various sarcomas, metastatic neoplasms for which the primary has not been found, and a variety of other malignant tumors of brain substance that could be present. My final diagnosis is tumor of the posteromedial frontal lobe involving the lateral wall of the hypothalamus and invading, if not originating in, the left optic nerve — probably malignant glioma.

DR. MEAGHER: Do you think his tumor was of a year's duration? Do you think his initial symptoms in which he had apparently a scotoma were related to his terminal illness?

DR. HUNT: I think probably not. Certainly I don't think the red, inflamed eye was, because there was never any recurrence of any signs of extracranial inflammation. What this "occasional light spot" in the central vision of the left eye really means, I don't know.

DR. MEAGHER: Ordinarily, what do you think of first in a patient with rapid loss of visual acuity without pain?

DR. HUNT: And with virtually no findings on funduscopic examination? This is the classic syndrome of what the ophthalmologist refers to as retrobulbar neuritis in which neither the patient nor the doctor can see anything. It's a dangerous diagnosis. In the first place, it ought to be translated "retrobulbar neuropathy," and a very common cause of retrobulbar neuropathy is retrobulbar neuritis, but another common cause of retrobulbar neuropathy is pituitary adenoma, parasellar tumor. So the diagnosis can't be taken lightly. The rapid onset, the rapid progression and stabilization, however, fit this general category of disorders until you begin to find, as we said early, that there is more to it than this.

DR. MEAGHER: Given a patient with idiopathic or asymptomatic optic atrophy, should this be investigated in any way?

DR. HUNT: Our policy has been that any progressive, unexplained — and take careful note of both those words — any progressive, unexplained blindness calls for surgical exploration of the optic chiasm regardless of negative radiographic information. An article has been written surveying a number of patients that have been managed with this policy and about 50 per cent of that series did have surgical disease of the optic chiasm. Within the past two years we have applied this to two patients and found in an elderly woman a craniopharyngioma, in a 40-year-old man a cystic tumor of the stalk of the pituitary. Both of these were benign lesions amenable to complete cure. So it's a sound policy and I think it's worth emphasizing.

DR. VON HAAM: You never discussed the possibility of metastatic disease and its importance for

clinical diagnosis. Are there any arguments pro and con?

DR. HUNT: Actually metastatic neoplasm has a tendency to act like a malignant glioma in that it progresses rapidly and is intracerebral, but it often has the relatively slow circulation of the meningioma. So perhaps it would not be a bad idea to point out that a metastatic tumor is as valid a diagnosis as primary tumor, even though we have not found the primary. I think one of the things that I have left out is the possibility of a tuberculous granuloma, which would give us this picture.

CLINICAL DIAGNOSIS
Malignant glioma

PATHOLOGIC DIAGNOSIS
Neuroblastoma

DISCUSSION OF PATHOLOGY

DR. LISS: At the time of autopsy there was found bilateral hemorrhagic bronchopneumonia. The main pathological findings were limited to the brain. On the base of the brain there were many cauliflower-like protrusions from the left frontal lobe. In the middle fossa there was a thickening of the left optic nerve and chiasm. On sagittal section a large neoplasm, fairly well circumscribed, has pushed the chiasm forward. There is also evidence of congestion and hemorrhagic infarct in the midbrain area, which is secondary to the increased intracranial pressure and the shift. The neoplastic mass was involving the hypothalamus, the posterior portion of the left frontal lobe, the optic chiasm, and the left optic nerve. The extension into the left frontal area looks well circumscribed. If you have a tumor originating from the chiasm, the optic nerve, or hypothalamus, it will not infiltrate but will invade brain from the base, and what you see is invagination of brain tissue caused by the pressure of the tumor from below. So we can get this appearance of separation between brain tissue and the tumor, which gives grossly the appearance of a metastatic lesion.

The histologic sections show the pleomorphism of this tumor. There are large giant cells, small round cells, and intermediate forms. The large cells form clusters which are well circumscribed and surrounded by vessels and perivascular connective tissue. In silver impregnation, the characteristics of the tumor cells are easily recognizable. The neurons and oligodendroglial elements can be demonstrated. There are distinct satellite fibers from the oligodendroglial cells and astrocytes. Some of the large neoplastic cells have distinct satellite formation of oligodendroglia. Of course, oligondendroglia always will arrange around neurons no matter whether this is a normal or a neoplastic neuron. This should be considered as an indicator that we are dealing with a tumor of ganglionic origin, not of glial origin. The oligodendroglia will never surround the large cells in glioblastoma in this fashion.

The neoplastic cells have many processes as in gangliocytoma of the sympathetic system. The least differentiated types are the large cells with few processes. The large number of processes throughout this tumor is derived both from the neoplastic cells and from the glial elements. The poorly differentiated neuroblastic elements form characteristic islands. The optic nerve is markedly enlarged. The central area of the optic nerve is unchanged except for some increase in glial population which should be regarded as reactive. Only few nerve fibers are surviving; they are thickened and form bulbs and skeins. These signs of destruction explain the interruption of function by pressure. The meninges of the optic nerve are infiltrated by tumor cells.

In conclusion, we are dealing here with a malignant neoplasm which should be designated as ganglioblastoma, and because of its neuronal characteristic I would assume that this neoplasm arose in the hypothalamus. In the hypothalamus, areas of heterotopia frequently occur, and there is a possibility that a displaced island of not maturing neurons, located paraventricularly, can be a potential tumor.

General Discussion

DR. MEAGHER: When I explored this patient, there was a dense inflammatory reaction of the optic nerve and the basal portion of the frontal lobe was densely adherent and literally sharp dissection was necessary to dissect the arachnoid covering of the frontal gyri from the optic nerve. We felt that this man had neoplasm which we didn't find and we knew he would come back. It was a highly malignant tumor and it was not compatible with a life span of more than four to six months.

QUESTION: Retrospectively, would you have done a biopsy of the optic nerve? Was this part with the tumor in it available for biopsy at surgery?

DR. MEAGHER: We biopsied brain and found no contiguous neoplastic elements in the frontal gyri. We felt that if this were reactive fibrosis or gliosis secondary to an adjacent tumor, we should have had it in our frontal lobe biopsies, and we were left with what we thought at surgery was a granulomatous mass etiology unknown, possibly inflammatory. We had nothing to gain by biopsying the optic nerve and we maybe had a slim chance of losing something. Retrospectively, it would have been nice to biopsy the optic nerve, but I doubt if we would have found much in the nerve at that time.

DR. VON HAAM: If you had stuck a needle into the thalamic area, would definite injury result?

DR. MEAGHER: We don't like to put needles up into this area, either from laterally or below. I think we could have biopsied a piece of the tumor, but again, we were trying to hook up the optic nerve

and the adjacent frontal lobe. We saw a suprasellar mass, which was our diagnosis at the time of surgery.

QUESTION: Dr. Liss, was the immediate cause of death central nervous system involvement or was it something else?

DR. LISS: Bronchopneumonia was found also at the autopsy, but it was a contributing cause only. The cerebral neoplasm with resulting edema and shift was the cause of death.

QUESTION: Would syphilis with a gumma formation ever give a picture like this?

DR. MEAGHER: I think it can give a parenchymal inflammatory response but it wouldn't give a mass in the hypothalamus and progressive loss of vegetative function with focal neurologic deficit. I have not seen these gummas — these were long before my days. Can you recall any of these?

DR. VON HAAM: To me, there is no difference between gumma and tumor. They act alike.

DR. MEAGHER: You saw them quite frequently? Would they invade the hypothalamus? Would you ever see gummas originating in the hypothalamus?

DR. VON HAAM: In the hypothalamus they form round, circumscribed lesions.

DR. HUNT: I have seen one in that short two-year period before syphilis was stamped out. They certainly do deceive you. They look like gliomas when they are in the brain. They also can produce a syphilitic periostitis with hyperostosis and look like a meningioma.

DR. LISS: One case in our series is a 55-year-old woman who had a gumma of the medulla, which, although rare, does occur sporadically.

DR. HUNT: I would like to point out here that we knew roughly where something was going wrong and at what rate. This is the order in which you must approach the problem, and I think this problem was approached and handled as well as it could be handled.

Cornpicker's Pupil

A Clinical Note Regarding Mydriasis from Jimson Weed Dust (Stramonium)

James A. Goldey, M. D., Dover A. Dick, M. D., and William L. Porter, M. D.*

IN THE FALL of 1965 we had occasion to see a young man who presented with the single physical finding of a widely dilated left pupil. He was referred to a neurosurgeon who performed an extensive neurologic evaluation. However, no explanation was found. After four days the pupil was entirely normal.

Approximately two weeks later the same patient returned with both pupils dilated. At that time he made the observation that on both occasions he had been picking corn with a mechanical corn picker and had got dust in his eyes. Upon further questioning we learned that his cornfield contained considerable amounts of jimson weed (Stramonium). With no treatment his mydriasis completely subsided in several days.

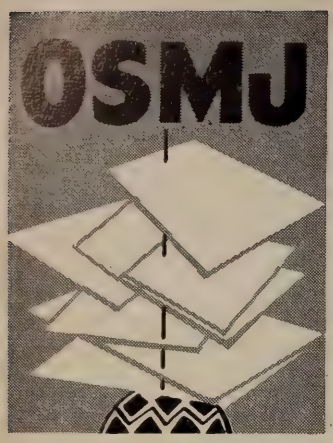
In the next two weeks we had occasion to see two other farmers, each presenting with mydriasis as his only physical finding. Each had been picking corn. Upon further questioning jimson weed was determined to be present in their cornfields.

Cornpicking requires that the operator on occasion climb under the machine on his back to remove obstructions. Each patient admitted to having perspiration running into his eyes frequently during the day's work. Stramonium leaf contains more than adequate amounts of atropine-like alkaloids to account for the mydriasis.

To the best of our knowledge, "cornpicker's pupil" has not been previously reported. In publicizing our recent experience with this phenomenon we hope that other farmers demonstrating this finding may be spared needless expensive and painful neurologic studies.

*Drs. Goldey, Dick, and Porter, are in general practice, Oxford, Ohio.

EDITOR'S NOTE: *Consult index for editorial comment on this interesting subject.*



NEWS AND Organization Section

Proceedings of The Council...

Report of Matters Considered and Actions Taken At the Meeting Held in Columbus, July 23 and 24

A REGULAR MEETING of The Council of the Ohio State Medical Association was held July 23 and 24, 1966, at Stouffer's University Inn, Columbus. All members of The Council were present except Dr. George Newton Spears, Ironton, Councilor of the Ninth District. Others attending the meeting were: Dr. Charles L. Hudson, Cleveland, President of the AMA; Dr. John H. Budd, Cleveland, chairman, Ohio delegation to the American Medical Association; Mr. Wayne Stichter, Toledo, OSMA legal counsel; Dr. William T. Washam, Columbus, executive secretary, Ohio State Medical Board; Mr. Denver L. White, director, Mr. Robert B. Canary, assistant director, and Mr. John Main, chief of administrative services, Ohio Department of Public Welfare; Mr. James Imboden, Columbus, American Political Action Committee; Mr. Charles H. Coghlan, executive vice-president, Ohio Medical Indemnity, Inc.; Messrs. Page, Edgar, Gillen, Traphagan, Campbell and Moore, members of the OSMA staff.

Introductions by the President

Dr. Meredith introduced Dr. Charles L. Hudson, Cleveland, President of the American Medical Association, and Mr. Jerry J. Campbell, Columbus, who joined the OSMA staff July 18, 1966.

Minutes Approved

Minutes of meetings of The Council held April 23-24 and May 27, 1966 were approved by official action.

Membership Statistics

The following membership statistics were announced by Mr. Page: OSMA membership as of July 22, 1966, 9,901, compared to a total membership of 9,830 on July 22, 1965, and 10,042 on December 31, 1965. He reported that of 9,901 members, 8,875 were affiliated with the AMA.

The Ohio State Medical Board

Dr. William T. Washam, Columbus, executive secretary of the Ohio State Medical Board, was introduced. Dr. Washam addressed The Council and discussed certain desirable changes in the Ohio Medical Practice Act. Dr. Washam emphasized the fact that the Act is a good one and basically sound. The new secretary expressed a desire for cooperation between his office and that of the Ohio State Medical Association.

A letter from the Academy of Medicine of Cincinnati with regard to enforcement problems was referred to the Ohio State Medical Board.

Department of Welfare Advisory Committee

Dr. Light reported on meetings of the Ohio Department of Welfare Advisory Committee.

Report on June AMA Meeting

Dr. Budd, chairman of the Ohio delegation to the American Medical Association, reported to Council on the 1966 annual meeting of the American Medical Association. He advised The Council concerning the

disposition of the following resolutions which originated from Ohio:

AMA Resolution No. 56 (OSMA House of Delegates Resolution No. 21 from Stark County), providing that all patients eligible for military dependents, medical care be afforded the same option of reimbursement provided for patients eligible for benefits under Public Law 89-97, was amended to add a provision for usual and customary fee and was adopted.

AMA Resolution No. 57 (OSMA Resolution No. 36 from Huron County), with regard to protection of the American Public against contaminated articles, was adopted.

AMA Resolution No. 58 (OSMA House of Delegates Resolution No. 23 from Summit County), on the subject of endorsement of the "open staff" for hospitals, was not adopted, but the AMA House reaffirmed four previous principles established by that body covering the subject of "open staff."

AMA Resolution No. 59 (OSMA Resolution No. 45 from Cuyahoga County), with regard to subscribers to Part B of Medicare being entitled to treatment as private patients, was adopted as introduced.

AMA Resolution No. 99 (OSMA Resolution No. 46 from the Second Councilor District) was regarding Civil rights pledges and agreements. The AMA adopted a substitute resolution asking the AMA to assist the state societies by working at the national level to eliminate the requirements for such agreements and pledges.

AMA Resolutions No. 73 and No. 105 on Medicare Regulation No. 5. A substitute resolution drafted and submitted by the Ohio delegation, covering a statement opposing sections of Medicare Regulation No. 5, was adopted by the AMA House of Delegates.

AMA Resolution No. 1 was introduced as directed by the OSMA Council. It specified that in the case of resolutions referred to AMA Councils and Committees, representatives of the states where the resolutions originated be asked to attend hearings thereon. The resolution was made permissive and adopted.

AMA Resolution No. 2, calling for quarterly sessions of the AMA House of Delegates and introduced as directed by the OSMA Council, was referred to the Board of Trustees.

AMA Resolution No. 3, on osteopathic internships and residencies in AMA approved programs, introduced as directed by the OSMA Council, was referred to the Board of Trustees.

Other Resolutions

Others of interest were AMA Resolutions No. 8 and No. 42 on usual and customary fee and AMA Resolution No. 53, a policy statement on government medical programs almost identical to the statement drafted by the OSMA Council on March 20, 1966 and contained in OSMA Medicare Newsletter No. 3. All were adopted on the floor of the House in lieu of a substitute statement recommended by the AMA Reference Committee "A" on Insurance and Medical Service. The motion to adopt the original resolutions was made by Dr. Budd, representing the Ohio delegation.

AMA Resolution No. 104, introduced by the Oregon delegation, was adopted. This resolution would make it unethical for a physician to replace a physician who had been displaced from a hospital staff because of his insistence on following the procedure of direct billing.

"Usual and Customary" Definition

Report H of the Council on Medical Service, which would have changed the definition of usual and customary fees for professional services, was referred back to the Council on Medical Service for further study, with a request to report to the House at the 1966 clinical convention. It was reported that the Ohio State Medical Association is requesting the privilege of appearing before the Council on Medical Service, since attempts are under way to interpose the "prevailing fee" concept into the definition.

American Medical Association dues were raised from $45 to $70 a year starting January 1, 1967.

Dr. Charles L. Hudson, Cleveland, was installed as President of the AMA.

Dr. Budd, chairman of the Ohio delegation, complimented the Ohio State Medical Association on its series of Medicare newsletters which have received acclaim throughout the country.

Director of Public Welfare and Staff

The Honorable Denver L. White, director of the Ohio Department of Public Welfare, then addressed The Council. Mr. White was accompanied by Mr. Robert Canary, assistant director and Mr. John Main, chief of administrative services. Mr. White expressed appreciation for the cooperation of the Ohio State Medical Association. He then reviewed the history of the public assistance program in Ohio and related the changes brought about by House Bill 376 in the 1965 Ohio General Assembly. Such bill placed aid for dependent children, aid for the blind, aid for the disabled, and aid for the aged under county administration supervised by the State Department of Public Welfare. He indicated that this will result in a single program approach and a more uniform one.

Following this, considerable time was devoted to a discussion of Title XIX. Subsequently, The Council adopted the following statement and asked that it be published in the *OSMAgram* for the information of the membership:

Text of Council Statement

The Council of the OSMA commends the Ohio Department of Public Welfare for its expressed interest in developing a usual, customary, and reasonable fee program as a basis for reimbursement of physicians for professional medical services provided welfare patients.

The usual, customary, and reasonable fee concept is in keeping with the policies of this Association as established by its House of Delegates and The Council.

For definitive purposes, usual, customary, and reasonable fee is defined as follows:

Usual — The "usual" fee is that fee usually charged for a specific service provided by an individual physician for his patient.

Customary — A fee is "customary" when it properly reflects the extent and nature of the services provided the patient.

Reasonable — A fee is "reasonable" when it meets the "usual and customary" criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration.

This Association assures the Ohio Department of Public Welfare that the usual review mechanisms for such programs will be readily available to the department.

In recognition of the fact that development of this program must be based on adequate fiscal resources being available for the department, The Council of the OSMA will, for the time being, cooperate with the department in a project whereby, pending development of fiscal and actuarial experience, each physician will bill his usual, customary, and reasonable fee and the department would reimburse the physician such a percentage of his usual, customary, and reasonable fee as is practicable under the fiscal circumstances now existing. It would be understood that the percentage reimbursement would represent the maximum amount available under these circumstances.

It would be agreed that this program would be followed until sufficient funds to provide full payment of the usual, customary, and reasonable fee are appropriated by the 107th Ohio General Assembly. It would be further understood that this Association would support heartily before the General Assembly the appropriation of such funds as may be required for an adequate and equitable program.

This Association would endeavor to inform its membership of the need for cooperation during this temporary situation. The Welfare Department also must endeavor to instruct welfare workers, the people of Ohio, and the members of the General Assembly as to the gross inequities of the program which have existed for 20 years.

This Association would point out that these welfare medical care programs were established by acts of the Ohio General Assembly and the United States Congress, and that the responsibility for adequate funding of such programs rests with the General Assembly and the Congress.

1966 Annual Meeting

Mr. Traphagan reported on the 1966 Annual Meeting in Cleveland. It was announced that the scientific programs were unusually well attended.

1967 Annual Meeting

Mr. Traphagan discussed plans for the 1967 Annual Meeting. In that connection The Council directed that all scientific programs be under the control of the Committee on Scientific Work and that the committee suggest the type and content of general session programs presented by other organizations.

Referral of Resolutions

The Council then took up resolutions adopted by the 1966 OSMA House of Delegates:

Amended Resolution No. 15, Hospital Admission — With regard to the interpretation of Amended Resolution No. 15, The Council concurred with opposition to additional forms for the certification of the necessity for the admission of Medicare patients to the hospital. The Council did suggest, however, that some statement of the necessity for admission is presently required by law and that any method used must originate with knowledge and approval of the medical staff.

(All that the Social Security Administration requires, according to information received at the OSMA Headquarters, is an entry on the progress notes of the physician, accompanied by his signature.)

Substitute Resolution No. 16, Reimbursement for Services of Hospital-Based Physicians — The OSMA staff was instructed to follow up on the resolution by petitioning the Director of Insurance to require removal from all prepaid hospital insurance plans provisions for benefits covering physicians' services.

Amended Resolution No. 24, Standardized Claims Form—A suggested standardized claims form developed to comply with the resolution was presented by the OSMA staff. In addition, forms used by Ohio Medical Indemnity, Inc., Medical Mutual of Cleveland and the Summit County Medical Society were discussed. The form recommended by the Health Insurance Council and approved by the Council on Medical Service of the American Medical Association was reviewed. All were submitted to the OSMA Insurance Committee with a request that a

single form be developed and submitted to The Council in September.

Resolution No. 30, Licensing Foreign Graduates — This resolution was referred to the Judicial and Professional Relations Committee.

Amended Resolution No. 32, Voluntary Health Insurance — This resolution, calling for the continuance of voluntary health insurance for persons 65 and older, was referred to the Insurance Committee of the Ohio State Medical Association.

Amended Resolution No. 37, Health Insurance for Migrant Workers — This resolution was referred to the Insurance Committee of the Ohio State Medical Association.

Editorially Changed Resolution No. 39 — To Upgrade the Education of the Hearing Handicapped — This resolution was referred to the Committee on Public Relations and Economics.

Substitute Resolution No. 29, Training More General Practitioners — This resolution was referred to the Committee on Education.

Amended Resolution No. 42, Defining "receipted bill" for Participants of Part B of Medicare — This resolution was discussed by The Council. The Council was advised of the passage of Resolution No. 22 at the AMA 1966 Annual Meeting in Chicago, which established AMA policy that the words "receipted bill" be changed in the law to "physician's bill." The Council voted to support and encourage action of the American Medical Association to obtain passage of this legislation.

Amended Resolution No. 17, Physicians, Ethics and the Corporate Practice of Medicine — This resolution was referred to the Judicial and Professional Relations Committee for implementation and the Executive Secretary was instructed to notify all county medical societies of its adoption by the OSMA House.

Reports of Councilors

The Councilors reported on activities in their respective districts.

Cleveland Academy of Medicine Amendments

The Council voted to approve amendments to the constitution and bylaws of the Academy of Medicine of Cleveland, subject to a minor clarification.

Jefferson County Amendments

The Council advised the Jefferson County Medical Society to clarify its proposed amendments by amending the bylaws section on the classification of members in order to include a classification of "retired membership."

Lawrence County Amendments

Proposed amendments to separate the office of Secretary-Treasurer to Secretary and Treasurer were submitted by the Lawrence County Medical Society. The Council expressed the opinion that these amendments were not properly drafted and authorized Mr. Stichter to prepare suggested amendments to carry out the purposes expressed by the society.

Lorain County Amendments

The proposed amendments to the constitution and bylaws of the Lorain County Medical Society were then considered. The Council requested the Executive Secretary to obtain clarification of proposed amendments to Section 1, Chapter 5, asking that it be specified by whom the dues of active members or associate members shall be "determined." It was also suggested that the percentage of dues for nonresident members be based on the "active" membership dues rather than on "regular" dues since there is no membership category specified as "regular."

Committee Reports

Athletic Injuries — The minutes of a meeting of the Joint Advisory Committee on Athletic Injuries held April 27, 1966 **were approved.** Mr. Gillen reported that the Advisory Committee had postponed the Postgraduate Institute on Athletic Injuries until 1967 and that the Joint Committee on Athletic Injuries would cosponsor with the Ohio State University Physical Education Department and Ohio High School Athletic Association a workshop for high school student trainers this year.

Rural Health — The Council **approved** the minutes of a meeting of the Subcommittee on Rural Health Scholarships held July 13, 1966, at which time Messrs. Harold L. Mast, Smithville, and Lawson C. Smart, Boardman, were selected as winners of the annual $2,000 OSMA scholarships.

Hospital Relations — On the recommendation of the Committee on Hospital Relations, The Council **approved** the cosponsorship of a one-day meeting on area-wide planning of health facilities with the Ohio Hospital Association and the Ohio Association of Osteopathic Physicians and Surgeons. The tentative date for this meeting is Sunday, January 15, 1967.

Emergency Nursing Procedures — A letter from the Ohio State Nurses Association, asking modification of the Ohio State Medical Association statement relating to emergency nursing procedures, was discussed by The Council. By official action, The Council expressed the opinion that it sees no reason to change the original Ohio State Medical Association statement.

Environmental and Public Health — The minutes of the first meeting of the new Committee on Environmental and Public Health held July 20 were presented by Mr. Gillen. The minutes **were approved** as presented.

Cancer — Mr. Traphagan presented the minutes of a meeting of the Ohio Cancer Coordinating Com-

new

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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mittee, Inc., held June 9, 1966 and they were approved as presented.

Mental Health — Minutes of a meeting of the Committee on Mental Health, held June 12, 1966, were presented by Mr. Traphagan.

The report carried with it the **approval** of the publication of a "Pocket Manual for Hospitalization of the Mentally Ill in Ohio." The manual on hospitalization of the mentally ill, with appropriate editorial amendments, will be mailed to all members of the Ohio State Medical Association and subsequently will become a part of the OSMA new member packet.

In addition, The Council **approved** the committee's work on the implementation of OSMA House of Delegates resolutions calling for the initiation of legislation to create a separate Department of Mental Health and Retardation in Ohio; establishing a position of Director of Mental Health who, if possible, would be a doctor of medicine; and establishing a Board of Mental Health to be appointed by the Governor, such legislation to be submitted by the committee to The Council for review prior to further implementation.

The mental health report contained plans for a steering committee for the purpose of bringing information to "primary care" physicians with regard to useful psychiatry. The idea of the steering committee **was approved** with the provision that the Ohio State Medical Association would pay the expenses of OSMA representatives only.

There was no action on the sponsorship of legislation to permit the State of Ohio to pay the cost of care of patients who have been declared mentally ill but for whom there is no room in the state hospital system. The cost involved would be for hospitalization in private psychiatric facilities. The Council accepted the idea in principle but took no action on the suggestion that legislation be prepared by the OSMA on this matter.

The Council discussed the proposal for a subcommittee of the Committee on Mental Health to study the problem and formulate a statement with regard to the misuse of LSD, marijuana and other consciousness expansion drugs and **approved** the study with a suggestion that other drugs be added to the study. The Council then **approved** the report as a whole, as amended, and commended the committee for the development of the manual.

Eye Care — The minutes of a meeting of the Committee on Eye Care held July 17 **were approved** as presented by Mr. Page.

The approval of the report carried with it approval of proposed revisions by the Ohio Department of Education in Program Standards for Special Education Units for Visually Handicapped Children, providing the four amendments developed by the Committee on Eye Care are included in the final draft of the revisions.

Fall District Conferences

Mr. Page discussed plans for the Fall District Conferences and pre-election activities. The Councilors were asked to encourage county legislative chairmen to complete the interviews of candidates in connection with these conferences.

Ohio Medical Indemnity, Inc.

The report of the Ohio Medical Indemnity Liaison Committee, presented in writing by the chairman, Dr. Robert E. Tschantz, was accepted for information by The Council with the deletion of Item 7 of the report. The text of the report follows:

1. OMI is in sound financial condition.

2. Only five cases have been referred to mediation committee on comprehensive policy compared to problem presented by Workmen's Compensation.

3. Blue Shield has been forced by some large employers to write special contracts around Medicare.

4. OMI has offered Blue Cross Plans an interim Blanket Policy to pay that portion of Blue Cross contract that pays hospital-based specialists. To date, no Blue Cross Plan has accepted this offer. In connection with this, OMI has met with state representatives of radiologists, pathologists, and cardiologists. Physicians representing these hospital-based physicians have indicated a desire to separate their bills — except the cardiologists.

5. The matter of billing procedures brought up by anesthesiologists has been answered as follows:

> "The request by OSMA Council had been reviewed by the Executive Committee of OMI and a memorandum had been prepared on this question which pointed out the administrative problems involved in the direct processing of OMI of claims filed for the services of anesthesiologists. This memorandum was dated March 15, 1966, and was reviewed by The Council of the OSMA at their meeting of April 23-24, 1966, and The Council of the OSMA asked "that officials of the Ohio Medical Indemnity, Inc. confer with responsible members of the Ohio Society of Anesthesiology, with the expressed hope that the principle of individual and direct billing may be extended to Blue Shield claims involving the services of anesthesiologists.
>
> "After considerable discussion it was agreed that it would not be appropriate at this time to change the OMI claim forms used throughout the State of Ohio, but it was agreed that the OMI claim form would be changed for claims filed in the Toledo area on an experimental basis so that the administrative staff would have

an opportunity to record the success or difficulties involved in a segment of the State, in the change of the traditional method of filing OMI claims for the services of anesthesiologists."

6. OMI has notified Blue Cross that it no longer will subsidize Blue Cross Medicare advertising.

Mr. Coghlan reported on progress in the development of coverage providing benefits to patients of medical specialists who are hospital-based. He announced that Blue Cross Associations have refused to transfer premiums covering medical services. As of this date, the Superintendent of Insurance has not permitted Ohio Medical Indemnity to cover Blue Cross subscribers in Ohio by issuing a blanket policy.

Mr. Coghlan announced that Ohio Medical Indemnity will offer and promote "riders" to Blue Shield contracts covering the services of hospital-based specialists.

The Council discussed the efforts of the radiologists in Ohio to bill for their own services, noting that the Ohio State Medical Association and the American Medical Association have both declared the billing for the professional services of a physician by a hospital is unethical and that such action by a hospital is the unlawful practice of medicine.

The Council instructed the OSMA staff to work through Dr. Paul A. Jones, Zanesville and Dr. M. M. Thompson, Toledo, in a survey of radiologists in the state to determine progress on the separation of contracts with hospitals involving medical care of patients and a change over to direct billing by the physician for services to his patients.

The general counsel of the Ohio State Medical Association was authorized to attend a meeting of the radiologists in Columbus on Thursday, July 28, 1966.

Problems arising from the policy of "coordination of benefits" recently adopted by various Blue Cross Plans in Ohio were brought to the attention of The Council through communications from several members. The Council instructed the Executive Secretary to assemble data on the subject of "coordination of benefits" and to refer the matter to the Insurance Committee for study.

Appalachia Program

Dr. Beardsley reported on developments in the Appalachia program. He submitted to Council for its information a letter from Dr. Robert R. Huntley, executive codirector, Health Advisory Committee, The Appalachian Regional Commission, Washington, D. C., accompanied by a letter to the West Virginia State Medical Society, which revealed certain amendments to the criteria of the program.

The Council asked that physicians be made aware of the implications of the program, that they be alert to developments in their own communities, and that they provide information to The Council of the Association with regard to these developments. It was suggested that county medical societies advise local health departments to consult with the societies in advance in developing a program.

AMA Report by Dr. Hudson

Dr. Hudson reported to The Council with regard to the American Medical Association discussions with the Federal government and problems now facing medicine concerning Medicare regulations. Discussing the document "Application of Criteria for Determination of Reasonable Charges," Dr. Hudson stated that the AMA has strongly recommended that the statement not be issued, or if one is believed necessary that the present one be completely rewritten.

With regard to a document entitled "Conditions for Coverage of Services of Independent Laboratories," Proposed Regulations — Subpart M, Part 405 (Regulations 5), Dr. Hudson pointed out that the regulations in this document should not apply to physicians' offices. He stated that the American Medical Association has pointed out to Commissioner Robert M. Ball of the Social Security Administration that it is clear that the law refers only to a lay laboratory that is independent from a physician's office.

A physician-operated laboratory is a physician's office, therefore should not be subject to the supervision or control by the Federal government. Such proposed regulations would establish a precedent for Federal regulation of medical practice and services that is not supported by law and which is not in the public interest, the American Medical Association has pointed out.

Air Pollution

A document concerning what a county medical society can do about air pollution, submitted by Dr. Tschantz who attended the AMA Conference on Air Pollution Medical Research in Los Angeles, March 2-4, 1966, was referred to the Committee on Environmental and Public Health.

Ohio Federation of Licensed Practical Nurses

The appointment of Dr. Henry A. Crawford, Cleveland, to the Advisory Committee of the Ohio Federation of Licensed Practical Nurses was approved by The Council.

Ohio State Nurses Association

The Council acknowledged receipt of a letter from the Ohio State Nurses Association regarding a combined meeting of the committees on legislation of the OSMA and OSNA. The Executive Secretary was instructed to acknowledge the communication and explain to the OSNA that special items of legislation are considered by The Council and by the special committees of the OSMA engaged in the areas of specific legislation under consideration and therefore the meeting of the legislative committees would not

be practicable. The Council requested that any proposed legislation be submitted in writing for study by the proper committee or The Council.

Compulsory Autopsies

A communication asking for legislation to make autopsies mandatory on patients dead on arrival in hospital emergency rooms was discussed. The Council expressed the opinion that these autopsies are a problem of the coroner and received this communication for information.

AMA Rehabilitation Conference

Dr. Henry A. Crawford, Cleveland, was appointed to represent the Ohio State Medical Association at the AMA Conference on Rehabilitation in Chicago, September 8-9, 1966.

Closed Chest Cardiopulmonary Resuscitation

A letter from the Ohio State Heart Association regarding closed chest cardiopulmonary resuscitation instruction for physicians was referred to the Committee on Education for implementation.

Ohio Hospitalization Benefits Committee

Dr. Crawford reported on meetings of the Ohio Hospitalization Benefits Committee. It was announced that Dr. Crawford has been appointed chairman of a subcommittee of that organization to study the problem of the removal of medical benefits from Blue Cross contracts.

Health Planning Project

The Council authorized the appointment of Mr. Gillen to the Advisory Committee to the Ohio Department of Health Centralized Health Planning Information Project.

Vocational Rehabilitation

A letter from Dr. O. L. Coddington, State Medical Administrative Consultant, Bureau of Vocational Rehabilitation, Ohio State Board of Education, and a fee schedule of the Bureau of Vocational Rehabilitation were received for information.

Symposium on Immunization

The Council **authorized** the President to appoint a representative of the Ohio State Medical Association to attend the Symposium on Immunization, October 17, 1966, in Atlanta, Georgia, such symposium being conducted by the AMA Council on Environmental and Public Health and cosponsored by the Communicable Disease Center, Public Health Service, U. S. Department of Health, Education, and Welfare.

Student AMA Advisor Appointed

The Council **approved** the appointment of Dr. Richard L. Fulton, Columbus, as advisor to the Student American Medical Association Chapter at the Ohio State University College of Medicine.

Ad Hoc Committee Appointed

A letter from Dr. Sol Maggied, Madison County, regarding the heavy burdens connected with the presidency of the Ohio State Medical Association, was discussed by The Council. The Council acknowledged Dr. Maggied's letter with thanks and authorized the appointment of an ad hoc committee to study the matter.

Cleveland Travel Committee

The Council received a request from the Travel Committee of the Cleveland Academy of Medicine, asking the OSMA to provide addressograph service in connection with promotion of tours sponsored by the committee and offering to reimburse the Association for this service. Permission was not granted by The Council for use of the equipment for this purpose because of standing policies. The Executive Secretary was asked to refer the Academy to the AMA Department of Circulation and Records.

ODH Laboratory Advisory Committee

In response to a request from the Ohio Director of Health, asking for suggestions for three appointments to the Ohio Department of Health Laboratory Committee, The Council authorized the submission of the names of the following physicians from which list the new appointees may be selected: Dr. Horace B. Davidson, Columbus; Dr. Gerald A. Wyker, Fredericktown; Dr. Charles Jean Cooley, Oberlin; Dr. Bernard Leslie Huffman, Jr., Toledo; Dr. John R. McKay, Warren; Dr. Robert P. Stafford, Dayton; Dr. Richard Gene Weber, Marion; and Dr. Ernest D. Davis, Hamilton.

Articles in NEW YORKER Magazine

The Council discussed a series of articles recently published by the magazine *New Yorker* on the medical profession. The staff was instructed to submit a letter to that magazine, pointing out, for the record, errors in the material.

Crippled Children's Program

A communication from Dr. H. William Porterfield, Columbus, with regard to problems in the Ohio Crippled Children's program, was discussed by The Council. By official action, the matter was referred to the Committee on Government Medical Care Programs for study.

Summit County Matter

A communication from the Summit County Medical Society, dealing with problems between the society and the Joint Commission on Accreditation of Hospitals, was received by The Council. The discussion centered on the right and responsibility of the medical society to determine the basic professional, ethical and moral qualifications of a person proposing to practice medicine in a community. The Council expressed the opinion that this is a matter

for proper inquiry by county and state societies. The Executive Secretary was instructed to interview the appropriate departments of the American Medical Association on the matter and to refer the entire situation to the Judicial and Professional Relations Committee for study.

Committee to Study Councilor Districts

The Council authorized the appointment by the President of the following committee to study the composition of the OSMA Councilor Districts: Dr. Robert C. Beardsley, Zanesville, Chairman; Dr. Richard L. Fulton, Columbus; Dr. Paul N. Ivins, Hamilton; Dr. P. John Robechek, Cleveland.

Federal Legislation

The Council received for information a report on several pieces of Federal legislation. Mr. Edgar reported that S. 3008, Health Planning Grants, to provide $10 million for fiscal 1967, had been recommended for passage by the Senate Labor and Public Welfare Committee, with $1 million to be made immediately available for community mental retardation center services, including staffing.

He also reported that the issue on legislation regulating transportation and treatment of research dogs was confused because of so many bills dealing with this subject, and that a Senate-House conference committee was attempting to resolve the issue; that Senator Hart (D-Mich.) had announced plans to resume hearings on his bill (S. 2568) to ban physicians from profiting on drugs and eyeglasses or any other appliances they prescribe; that Senator Long (D-La.) had introduced a bill (S. 3614) to require generic prescribing for medicare patients and all other public assistance patients.

It was announced that the next meeting of The Council will be held on September 9, 10, 11, 1966, in Columbus.

There being no further business, The Council adjourned.

Attest: HART F. PAGE
Executive Secretary

Dr. J. Martin Byers, Greenfield, former commander of the 112th Medical Battalion, 37th Infantry Division of the Ohio National Guard, was awarded a Certificate of Achievement at Camp Grayling, Michigan, where the division was in summer training. Dr. Byers retired from active military duty June 1, 1965, with the rank of colonel.

Officers of the Western Reserve University Alumni Association for this year are the following Cleveland area physicians: Dr. Joseph C. Avellone, president; Dr. Eduard Eichner, first vice-president; Dr. Edwin P. Kennedy, second vice-president; and Dr. Hermann Menges, Jr., secretary-treasurer.

AMA 20th Clinical Convention To Be Held in Las Vegas

A scientific program especially designed for the physician in practice is scheduled for the 20th Clinical Convention of the American Medical Association.

The four-day meeting in Las Vegas, November 27-30 will include scientific sessions on 18 major topics, three postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs, and a variety of scientific exhibits.

Of special interest are the postgraduate courses, which have been expanded to three topics: Obstetrics and gynecology, fluid and electrolyte balance, and cardiovascular disease. Each course will consist of three half-day sessions, each of which will feature several outstanding teachers. There will be a $10 registration fee for each course.

Lively discussion should be a feature of four Breakfast Roundtable Conferences. The topics: "An Agonizing Reappraisal of Cancer Chemotherapy," "The Problem and Potential of LSD," "The Management of Metabolic Bone Disease," and "Indication for Cardioversion."

An outstanding program of closed-circuit color television and more than 25 medical motion pictures will be presented.

Topics at the scientific sessions include: Scintillation scanning, radiation and cancer, clinical pulmonary physiology, gastroenterology, futuristic diagnostic and therapeutic tools, neck pain, antibiotics, urology, aerospace medicine, unconsciousness, dermatology, juvenile diabetes, endocrine and metabolic diseases, pediatrics, surgery, hematology, psychiatry, and otolaryngology.

Scientific and industrial exhibits and all scientific meetings will be in the newly expanded Las Vegas Convention Center.

The AMA House of Delegates will meet in the Dunes Hotel and Caesar's Palace.

The Eighth National Conference on the Medical Aspects of Sports will be held in conjunction with the Clinical Convention. A day-long program of discussion of problems faced by team physicians at all levels of athletic competition will be discussed. The meeting will be Sunday, November 27, at Caesar's Place.

Dr. Mark T. Hoekenga, Cincinnati, was featured in a special article in the *AMA News* of August 15, as the author of "A Physician's Vietnam Diary." the diary formed the body of the article.

AMA Takes Firm Stand at Convention; Ohioans Play Leading Roles

A RECOMMENDATION that physicians "voluntarily and under ordinary circumstances" adopt the practice of billing their Medicare patients directly was adopted by the AMA House of Delegates at the 115th Annual Convention in Chicago.

The House recommendation is based on a report submitted to it by the Board of Trustees and resolutions from three state delegations.

This action was the keynote in the AMA House of Delegates' determination to uphold the doctor's integrity and to preserve the physician-patient relationship in the face of governmental encroachment on medicine.

Ohioans played leading roles in all phases of the AMA Convention.

• Ohio's Dr. Charles L. Hudson, of Cleveland, Excerpts from the diary formed the body of the article. points in his inaugural address on pages 939-940.)

• Ohio's Mrs. Karl F. Ritter, of Lima, was named President-Elect of the Woman's Auxiliary to the AMA. (Refer to story in August issue, page 830.)

• Ohio's delegation introduced nine resolutions in the House of Delegates, several of which developed in the Ohio House of Delegates, and most of which were acted upon favorably, or referred for further study.

• Many hundreds of Ohio doctors were among the 12,445 physicians who attended the Convention. Added to this number were members of their families, guests, etc., bringing the total to 35,506.

Leading Roles in House

Members of Ohio's delegation took leading roles in deliberations of the AMA House of Delegates and had a part in the strong position taken by the AMA in regard to direct billing and other principles set forth in the adopted statement entitled "Physician's Role in Medicare." (See text of this statement on pages 940-941.)

One Ohio resolution entitled "Subscribers to Part B of Medicare Are Entitled to Treatment as Private Patients" was adopted in toto and became a part of AMA policy. This resolution came out of the OSMA House of Delegates at the last Annual Meeting. (Refer to July issue of *The Journal,* page 706.)

A resolution drafted by Ohio delegates as a substitute resolution, regretted that publication of Medicare Regulations #5 was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared:

"Resolved, That the House of Delegates instruct the Board of Trustees and the Executive Vice-President to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and other interested medical organizations be allowed reasonable time to study, and to submit, to the Social Security Administration data, views or arguments and pertinent constructive comments and suggestions.

"Resolved, That to preserve the professional independence of medical practice that the Board of Trustees and officers of the AMA be instructed to immediately inform the membership that Medicare Reg. #5 will not apply to physicians (whether hospital-based or not) who

"1. have no financial relationship with a hospital covering medical services to patients

"2. do not accept assignments but bill directly and be it further,

"Resolved, That *The AMA News* and other appropriate media be used to advise all physicians who are developing contractual relationships with hospitals for professional service that they should delay the finalization of any agreement pending further analysis of the implementing regulations."

Oath of Compliance

Ohio's long fight against the arbitrary demand on the part of some welfare agencies for an oath of compliance under the Civil Rights Act of 1964 was taken up by the AMA.

It was pointed out that the Civil Rights Act of 1964 does not require an oath of nondiscrimination.

It was further pointed out that such a demand for an oath of compliance was unacceptable to physicians who have traditionally treated patients regardless of race, color, creed, or national origin.

The original resolution introduced by the Ohio delegation came out of the OSMA House of Delegates. The AMA substitute resolution reads as follows:

"That the Board of Trustees and the officers of the AMA take whatever steps are necessary on the national level to assist the state associations in securing the adoption by state agencies of procedures under

the Civil Rights Act of 1964 which do not require a participating physician to sign any statement or agreement of compliance as a prerequisite to being paid for his professional services under a federally assisted program."

Ohio Delegation Commended

The AMA House of Delegates commended the Ohio delegation for its continued efforts to further the principles of freedom of choice of physicians and free competition among physicians. In rejecting an Ohio resolution that originated in the OSMA House of Delegates on "open staff" hospitals, the House of Delegates reaffirmed a statement adopted in December, 1959 as follows:

"The American Medical Association firmly believes freedom of choice of physician and free competition among physicians should be preserved and cherished as fundamental principles which have, in large part, been responsible for the high standard of medical care in the United States and the leadership of American medicine throughout the entire world."

Additional Meetings Proposed

A resolution presented by the Ohio delegation would require the AMA House of Delegates to meet four times a year in Chicago for the transaction of business. These meetings would be in addition to the present Annual and Clinical meetings. The AMA House of Delegates adopted the recommendation of the reference committee that the resolution be referred to the Board of Trustees with the request that this problem be studied and a report be presented to the 1966 Clinical Session to be held in Las Vegas.

Military Dependents' Care

Another OSMA House of Delegates' resolution entitled "Direct Reimbursement Under Military Dependents Medical Care Act" urged "that all necessary action be taken in order to provide that patients eligible for benefits under Public Law 569 be afforded the same option of reimbursement as is provided for patients eligible for benefits under Public Law 89-97, Part B."

The AMA House of Delegates adopted the resolution with an additional resolve that fees provided under the Military Dependents Medical Care program be the physicians' "usual and customary charges."

To Study Osteopathic Question

The AMA House of Delegates referred to the Board of Trustees "because of the complex nature of these matters" an Ohio resolution in regard to osteopathic physicians. The resolve portion of the Ohio resolution read as follows:

"That the House of Delegates of the AMA instruct the Council on Medical Education to develop a method whereby qualifications of osteopathic physicians who are willing to subscribe to the Principles of Medical Ethics of the AMA and who express the wish to join a component county medical society may be evaluated in order to determine eligibility for intern and residency training in AMA approved hospital programs, without jeopardizing the hospital's accreditation status."

Hearings Before Board

An Ohio resolution urged the establishment of a policy of the AMA to the effect that when resolutions are referred to the Board of Trustees, Committees or Councils, that "an invitation be extended to representatives of the introducing delegation to participate in hearings and discussions of such resolutions."

The AMA House of Delegates adopted a recommendation of the reference committee making the policy permissive instead of mandatory by stating that "an invitation **may** be extended. . ."

Contaminated Articles

With slight amendment, the AMA House of Delegates adopted an Ohio resolution in regard to contaminated articles imported from other countries. The resolve part of the resolution as adopted reads as follows:

"That the appropriate committee of the AMA be instructed to continue to work with the proper public health authorities to insure that the health of the American public is protected from such dangers."

This resolution originated in the OSMA House of Delegates.

The Ohio Delegation

Because the number of AMA members in this state went over the 9,000 mark last year, Ohio for the first time had ten delegates in the AMA House of Delegates.

All of Ohio's delegates were present. They are: Dr. George W. Petznick, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. Theodore L. Light, Dayton; Dr. Edmond K. Yantes, Wilmington; Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Frederick P. Osgood, Toledo; Dr. Charles A. Sebastian, Cincinnati; Dr. Edwin H. Artman, Chillicothe; and Dr. Robert E. Tschantz, Canton.

Also present were the following Ohio alternate delegates: Dr. H. T. Pease, Wadsworth; Dr. Robert S. Martin, Zanesville; Dr. Kenneth D. Arn, Dayton; Dr. Harry K. Hines, Cincinnati; Dr. P. John Robechek, Cleveland; Dr. Frank F. A. Rawling, Toledo; Dr. Robert N. Smith, Toledo; Dr. Philip B. Hardymon, Columbus; and Dr. Henry A. Crawford, Cleveland.

Ohioans on Committees

Also in the House of Delegates were Dr. Walter J. Zeiter, Cleveland, delegate from the Section on Physical Medicine, and Dr. Donald Glover, also of

Cleveland, alternate delegate from the Section on General Surgery.

Three Ohoians served on Reference Committees of the House of Delegates.

Dr. Lincke was on the Committee on Public Health and Occupational Health.

Dr. Light was on the Committee on Rules and Order of Business.

Dr. Sebastian was chairman of the Tellers Committee.

Dr. Petznick was named to the Judicial Council of the AMA to succeed the late Dr. James H. Berge, of Seattle, Wash.

Present as interested observers in the AMA House of Delegates were the following OSMA officers: Dr. Lawrence C. Meredith, President; Dr. Robert E. Howard, President-Elect, and Dr. Henry A. Crawford, Immediate Past President.

Accompanying the Ohio delegation to Chicago were Hart F. Page, OSMA Executive Secretary; Charles W. Edgar, Director of Public Relations; Herbert Gillen, and Michael Traphagan, of the OSMA executive staff.

Circumventing Separate Billing

The House of Delegates declared it unethical for a physician "to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing."

The House adopted a resolution, introduced by the Oregon delegation, which cited the *Principles of Medical Ethics* that a physician shall not dispose of his services to a third party or "lay" organization.

The reference committee which considered the resolution had recommended to the House that it be referred to the Board of Trustees because of apparent unsolved legal issues involved in such a resolution. The House voted to adopt the resolution, however.

IMPLEMENTATION DELAYED

The AMA Board of Trustees last month announced that it was delaying implementation of this resolution following an inquiry from and discussion with the Department of Justice. The Board said it would report on the matter to the House of Delegates at the 1966 Clinical Convention in Las Vegas.

The resolution stated that "A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this principle."

The principle of separate billing by "hospital-based" physicians has been endorsed by the AMA, the American College of Radiology, the American College of Pathologists and others, the resolution noted.

Multiple Coverage Insurance

The House of Delegates approved a report of the Council on Medical Service in regard to Multiple Coverage in Voluntary Health Insurance.

It was pointed out in the report that the problem of over-insurance arises when the person insured under two or more contracts becomes entitled to reimbursement which exceeds the expenses against which the individual has insured himself, often resulting in a profit.

The following statement of policy in regard to group policies adopted by the House is entitled "Coordination of Benefits in Health Insurance Contracts":

"Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar.

"A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses.

"Therefore, the American Medical Association encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance."

AMA Dues Increase

By a vote of 168 to 46, the House approved an increase in AMA annual dues from $45 to $70, effective January 1, 1967, thus confirming a Board of Trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

"It is quite apparent that the programs necessary to serve the needs of the members of the Association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees. Your Reference Committee reaffirms its confidence in the judgment of the Board of Trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the Association. The Board of Trustees is the Committee elected by the House of Delegates to investigate and control the finances of the Association. The appointment of any other committee to perform this function would be most inappropriate."

In Inaugural Address, Dr. Hudson Warns Against Expansion of Federal Role

OHIO's DR. CHARLES L. HUDSON, of Cleveland, was inaugurated as 121st President of the American Medical Association at gala ceremonies during the AMA Annual Convention in Chicago. He was named President-Elect at last year's Convention in New York City after serving on the Board of Trustees.

After Dr. Hudson received the gavel from 1965-1966 President James Z. Appel, of Pennsylvania, and presented his inaugural address, he and Mrs. Hudson were guest of honor at a reception cosponsored by the AMA and the Ohio State Medical Association.

In his inaugural address before the House of Delegates, Dr. Hudson told the House, "I am not an apologist for medicare, nor for the first steps we take in it. I am, however, trying to make a realistic assessment of what I think is important, relatively, and what is not. For, if we exhaust our energies in the wrong defense, our cause may well be lost."

He noted that physicians in private practice apparently will be working by the side of government physicians "under many circumstances in which we still have a choice . . . unless we are alert, and take a positive attitude about our responsibilities and choices of action, we might one day be astonished to find that instead of working side by side with these people, we are working at their direction, following plans which they alone drew."

He urged that physicians maintain communications with government, to understand its problems as well as to expect it to understand theirs, and concluded:

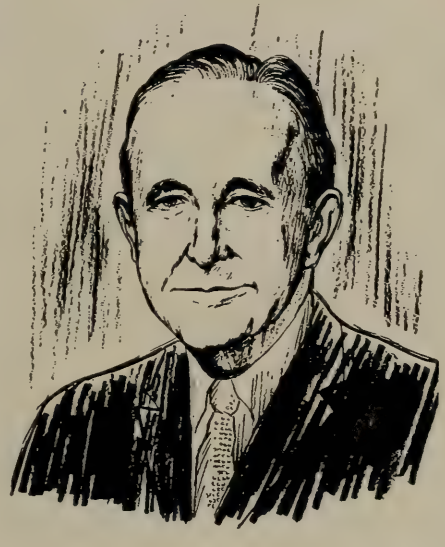
"We have been handed a challenge that is unlike any we have faced before. We must be tireless in our efforts to meet it, and meet it well, for the ultimate benefit of our profession and — more important — for the ultimate benefit of the patients we serve with our judgment, our skills and our very lives."

Advice to M. D.'s

Dr. Hudson said he proposes physicians use the tools provided and developed by their backgrounds and educations "to make the most, for our patients and our colleagues, of this new program . . . and to prevent extension of it, without demonstrated need, toward a national health service."

Dr. Hudson said several worries deter many physicians from supporting medicare, such as restriction of freedom of professional judgment, imposition of new clerical tasks, and the implication and assertion that the government must intervene to assure adequate medical care.

"However, these factors to my mind are not the real threats of the Social Security Amendments," he said. "Rather, it is the possibility, through reduction of the age limit under Title 18 and elevation of the eligibility income level under Title 19, of expansion to a national health service, covering everyone and financed from the federal treasury exclusively."



Charles L. Hudson, M. D.

Federal Paternalism

Dr. Hudson said that would be the "epitome of a widely supported philosophy that I abhor," in which the federal government is assigned responsibility for the solution of all problems.

Dr. Hudson offered these proposals "to counteract what offends our beliefs and aspirations":

- Demonstrate the competency of the private field of medicine to perform necessary technical, professional and administrative services by (A) showing how physicians evaluate the quality of care provided by the profession; (B) reappraising medical manpower and facilities in relationship to service demands; (C) evaluating the kinds and numbers of services we should have in order to provide "the

comprehensiveness of health care that is now being sought."

- Do everything possible to arrest the trend toward dependency on government, particularly where medicine is concerned, and in all other fields wherever possible.
- Encourage the government to confine its activities — in the organization of health services for those who are not its wards or dependents — to the overall stimulation and support of private enterprise.
- Continue to offer to the government the knowledge and the competency of the health profession in consultation and in cooperation, but with the health profession and the insurance and prepayment plans, acting as strong, independent agencies, not as extensions of the government.

On the last point, Dr. Hudson said it was the intention of the founding fathers of the nation that there be interaction between the government and governed.

Physician's Role in Medicare

The American Medical Association House of Delegates, at the Annual Convention in Chicago, adopted the following report, "Recommendations on the Physician's Role in Medicare," which was prepared by the AMA Council on Medical Service.

Billing Procedures

The Council points out that the physician is legally entitled to set his own valuation upon his services, to bill his patient for services directly, and to conduct himself in this respect essentially as though the medicare program did not exist. The Council is persuaded that this approach will be the least productive of misunderstandings with patients, the least demanding on the time of the physician and his office assistants, and the least disturbing to normal physician-patient relationships. If the direct billing approach is used, the physician will not be involved in the multitude of complexities involved in "assignments" — all of which may be properly identified as matters of concern between the beneficiary and the program carriers and fiscal intermediaries. Specifically, by using direct billing the doctor will not need to concern himself with:

a. The eligibility status of the patient and extent of coverage;

b. A distinction between "covered" and "excluded" services;

c. The status of the Part "B" deductible;

d. The application of the $20 outpatient diagnostic service; deductible (Part "A") as a credit toward the $50 Part "B" deductible;

e. The application of the "three month carry over" provisions from a previous calendar year to the Part "B" deductible;

f. The 20 per cent coinsurance provisions with the inevitable need for double-billing when assignments are accepted;

g. The technical problem of calculating the 20 per cent coinsurance factor prior to notification of the fee determined by the carrier as "reasonable";

h. The relation of what the physician feels his service is worth as opposed to what the carrier defines as a "reasonable" charge;

i. The presence or absense of supplementary or complementary coverage;

j. Limitations of payment for outpatient services for psychiatric conditions; and

k. The use of prescribed forms.

l. Direct billing does not require the listing of a diagnosis on the receipted bill.

It is to be noted that the patient will be dependent upon the cooperation of the physician to obtain his reimbursement from the medicare program, since he will need to submit a receipted bill which properly identifies the beneficiary, the physician, the date of service, the nature of the service given, the place of service (home, office, hospital, etc.) and the charge made.

The Council suggests that the physician bear in mind these requirements in adapting his personal billheads to this use in case he prefers not to use the "Request for Payment" form which is to be provided for this purpose.

The over-all conclusion of the Council on Medical Service is that under ordinary circumstances direct billing of patients will prove superior to the acceptance of assignments.

Utilization Review Committee Requirements

Physicians will need to decide whether or not they are willing to serve as members of a committee which is required to pass judgment on the medical need for continuing in-hospital service of extended stay cases. Although many physicians may have reluctance to so serve, it should be noted that such review is a legal requirement if any institution is to qualify as a provider of service. If the mandated review is not carried out by an in-hospital staff committee it will necessarily be provided by an extramural committee which may well involve physician employees of a state agency or a carrier. The clear choice facing the hos-

pital is that of doing its own reviews or having its hospital records reviewed by outsiders.

The Council on Medical Service points out that utilization study, unrelated to extended-stay review, is important to foster as an educational hospital staff project and as a valuable mechanism for quality control. It urges hospital staffs not to let this activity suffer because of entanglement with extended-stay review. For this reason the Council recommends that a hospital staff should consider compliance with the requirements of the regulations in formulating an acceptable utilization review plan. In the event that difficulties develop, it is recommended that these be carefully documented. Utilization study should be kept scrupulously distinct from extended case review, and, if necessary, due notification should be given the administration of the hospital that some extramural mechanism for extended-stay case review will be required if this staff function cannot conscientiously be continued. The documentation of the difficulties in extended-stay case review should be fully provided to the local county medical society for transmission to the state society and the American Medical Association.

Impact on Medical Education

The Council on Medical Service recommends to the House of Delegates that careful attention be paid to the impact of PL 89-97 and PL 89-238 in postgraduate medical education programs.

Collection of Data on Program Operation

The Council on Medical Service stresses the need for reporting by individual physicians and by hospital staff organizations problems arising in respect to the medicare program. This should encompass any factors which complicate the provision of medical care or cause a deterioration in the quality of the care provided. Such reporting should be specific and should document any allegations which may be made. These reports should be submitted to the appropriate county medical societies for transmission to the state medical societies and the American Medical Association.

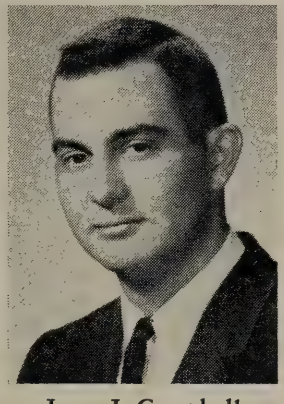
Advisory Committee

It is further recommended that the present Advisory Committee of the Board of Trustees be continued for the purpose of maintaining liaison with the Secretary of Health, Education, and Welfare, with appropriate officials in the Administration, and with congressional leaders. It is to be hoped that through these channels it may be possible to promote desirable regulatory changes, or to initiate necessary measures for amendment or repeal of undesirable portions of the Law.

New Member Joins the Staff at OSMA Headquarters Office

A new member has joined the Executive Staff of the Ohio State Medical Association with the appointment of Jerry J. Campbell to the position of Administrative Assistant. The appointment was announced by Dr. Lawrence C. Meredith, OSMA President, after conferences between Campbell, the Executive Staff, and the Association's officers.

Mr. Campbell is a graduate of Ohio State University, where he majored in economics and sociology and in 1960 received a B. S. degree in Agriculture. He received an honorable discharge from the Navy, then went into the insurance business in Columbus, where he gained six years of experience in that field.



Jerry J. Campbell

Diversified extracurricular activities at high school in Pewaukee, Wisconsin, included football, baseball, the band, the science club of which he was president, and the camera club of which he was treasurer.

In college, his campus interests also turned to group activities. In the dormitory, he was proctor and group leader, and served a term on the dormitory senate. He was pledged to Alpha Gamma Rho and served as pledge trainer and secretary. During his senior year, he was recording secretary of Ohio Staters, Inc., a community service organization.

Campbell was employed at the Columbus headquarters of the Nationwide Mutual Insurance Company from 1960 until his recent appointment with the OSMA staff. Positions there included those as life and health policy issue supervisor, coding and policy issue supervisor, Ohio 65 claims supervisor, and health policyholders service manager.

Associated occupational activities at Nationwide included a term as vice-chairman of the safety committee, and a tour as coordinator of the credit union and the Red Cross blood lending program.

He completed several basic courses in life and health insurance sponsored by the Life Office Management Association and Health Insurance Association of America. He belonged to Toastmasters International, and served as master at arms and administrative vice-president of the local group.

As Administrative Assistant in the OSMA headquarters office, Campbell will serve as secretary to several of the Association's Committees, do liaison work, arrange meetings authorized by OSMA officers, participate in the Association's legislative activities, and perform other duties as they arise.

Jerry Campbell and his wife Roberta are the parents of two daughters, ages 3 years and 1 year.

Outstanding Scientific Exhibits At the OSMA Annual Meeting

OUTSTANDING FEATURE at the 1966 OSMA Annual Meeting in Cleveland, May 24-28, was the Scientific and Health Education Exhibit. In keeping with a policy recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for certain exhibits designated as outstanding by the judging committee. This year seven exhibits were selected to receive the special honors which included mounted and engraved plaques, certificates and monetary awards. The committee designated three exhibits in the field of teaching, and three in the field of original investigation to receive respectively the gold, silver and bronze awards, and named a seventh exhibit to receive a special award. Following are brief descriptions of two of these award-winning exhibits.

Exhibit on Breast Cancer Wins Silver Award in Teaching

Silver Award winner in the field of teaching at the 1966 OSMA Annual Meeting was an exhibit entitled "Simplified Treatment of Breast Cancer," sponsored by Dr. George Crile, Jr., and Dr. C. B. Esselstyn, of the Cleveland Clinic Foundation.

The exhibit was designed to show that in clinical Stage I of breast cancer, when there is no palpable involvement of the axiliary nodes, simple mastectomy without prophylactic irradiation therapy gives better results from the standpoint of survival up to eight years than did conventional radical mastectomy with or without irradiation. The rationale behind this simplification of treatment lies in the immunologic importance of regional lymph nodes in the resistance of the host to its cancer.

In mice, as Mitchison has shown, immunologic resistance to an homologous cancer lies largely in the regional nodes. In the clinic's laboratory, investigators have been able to decrease resistance of mice to cancer by removing regional nodes, and have been able to increase the incidence of metastasis by any operation that removed regional nodes that drain a cancer. This applies only in the early stage of the cancer. Once the cancer is advanced, immunologic resistance, if any, has spread throughout the body.

The work portrayed in the exhibit was reported in *Surgery, Gynecology and Obstetrics,* May, 1965, Vol. 120, pp. 975-982, under the title "Rationale of Simple Mastectomy Without Radiation for Clinical Stage I Cancer of the Breast."

Exhibit on Urinary Diversion Awarded in Research Field

In the field of original investigation, the Silver Award was presented to Dr. Arthur A. Roth, of Cleveland, for his exhibit entitled, "Transabdominal Transperitoneal Bilateral Omentoureterostomy."

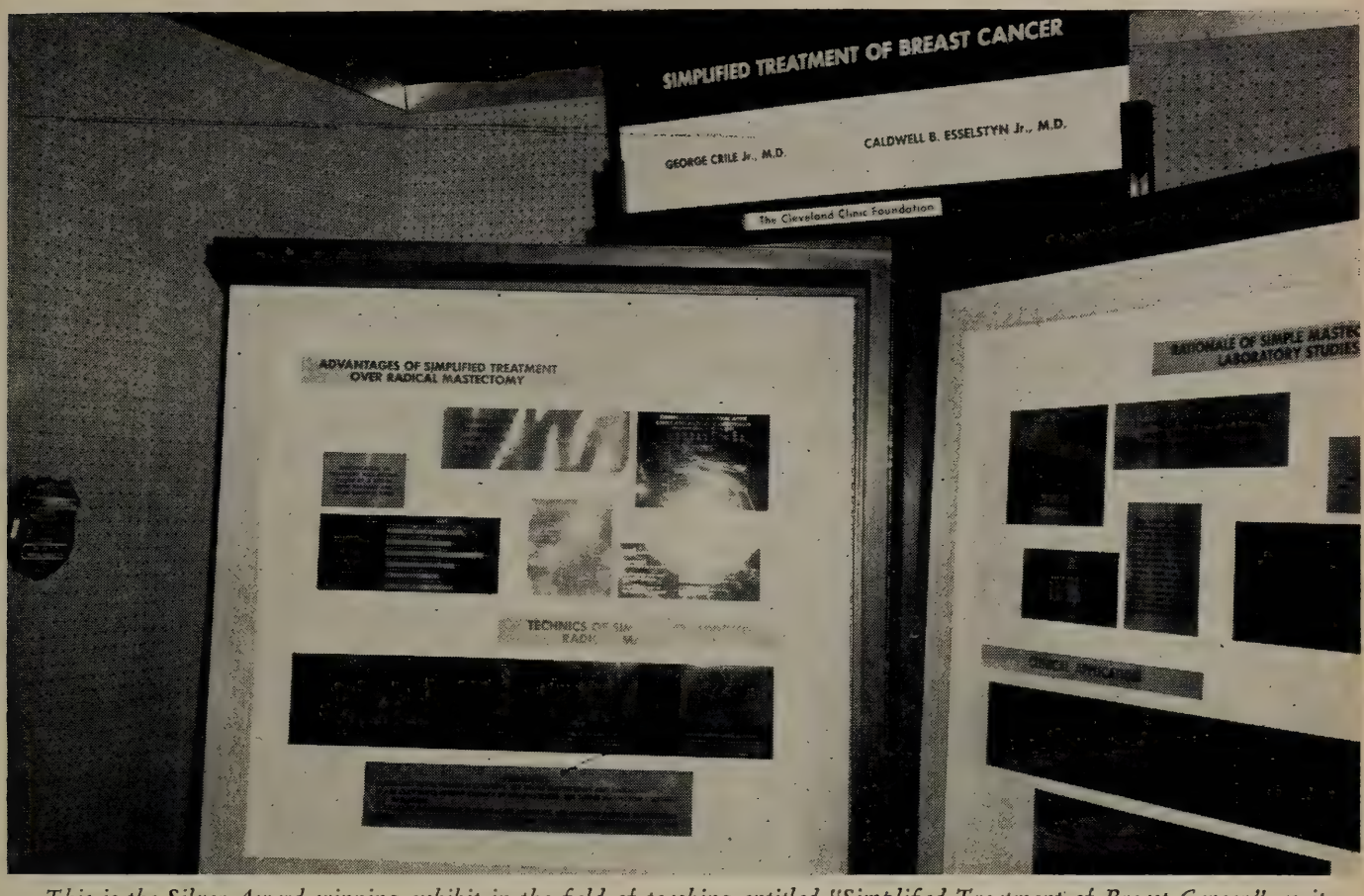
This exhibit depicted a new method of urinary diversion which makes it unnecessary to use the bowel as a urinary conduit. In the left panel, the exhibit presented the history and methods of urinary diversion. The center panel showed diagrams of the technique of omentoureterostomy, early and late kodachrome enlargements of the stomata, and intravenous pyelograms of the postoperative results. The right panel delineated what the sponsor feels are the advantages of this procedure over the use of bowel conduits.

Dr. Roth described the procedure as follows:

Omentoureterostomy is essentially a method of making a sleeve out of the omentum to protect and vascularize the terminal ureter in its egress through the abdominal wall. In all but one of a series of eight cases, the umbilicus and fascia were excised and the omentum split so that it could be wrapped around each ureter. Before the omentum and the ureter are brought out, interrupted catgut sutures are placed in the peritoneum and muscle layers for later suture to the omentum. The omentum is then brought out and split in order to make the sleeve.

The ureters are sutured to the omentum with interrupted 000 and 0000 chromic catgut through the serosa of the ureter. The omentum is sutured to itself with 00 catgut to make the sleeve. Silk sutures,

Silver Award Winning Exhibits



This is the Silver Award winning exhibit in the field of teaching entitled "Simplified Treatment of Breast Cancer," as it was shown at the 1966 OSMA Annual Meeting in Cleveland. The awarded plaque is shown on the extreme left. (See facing page for additional information.)



Dr. Arthur A. Roth, right, is holding the plaque presented for the Silver award winning exhibit in the field of original investigation. The presentation, entitled "Transabdominal Transperitoneal Bilateral Omentoureterostomy," was shown at the 1966 OSMA Annual Meeting. (See facing page for explanation.)

again interrupted, anchor the omental sleeve to the skin. The omentum is sutured around both ureters below the peritoneum as well. The ureters are fish-mouthed and sutured to the omentum. The collecting bag is placed over the stomas in the operating room without intubation of the ureters.

When cystectomy is performed on men, the prostate and seminal vesicles are included, a panhysterectomy is done on women. A long transverse incision from the anterior superior spine of the ilium to the opposite anterior superior spine is used. The rectus sheath and aponeurosis are cut in the line of the incision. The procedure is done under spinal anesthesia. A Cherny procedure is done when relaxation is incomplete.

This method has been used in eight patients—the oldest being 26 months postoperative. Six patients had carcinoma of the urinary bladder and in four of these, total cystectomies were done. Two patients, on whom cystectomy was not done, died following palliative procedures. One died from pulmonary emboli in the third week. Both of the patients had widespread metastases and the procedure followed because of excessive hematuria; no other procedures were planned.

One patient died of a stroke and cardiac failure three months after operation, and another from renal cortical abscesses after six months. In the latter patient, no hydronephrosis or ureteral obstruction was observed postmortem. Operation was performed on one patient who had a severely obstructed left ureter (with no renal function on that side due to tumor and radiation fibrosis) from carcinoma of the cervix with the rectum involved by fibrotic process. One patient (at the time of presentation only 12 weeks postoperative) had a primary carcinoma of the right seminal vesicle with no renal function on the right side as a result of bladder and ureteral involvement.

Postoperatively all patients were given the usual intravenous fluids and a Levin tube for three days. All received chloramphenicol, initially intravenously and later orally. One patient in whom pyelonephritis developed on the right side in the sixth postoperative month, responded well to chloramphenicol. The ureters remained patent in all cases and no small bowel obstruction has yet occurred.

Opportunities for physicians to receive residency training in Public Health Service hospitals are described in an illustrated booklet, entitled "Residencies for Physicians, Public Health Service Bureau of Medical Services," PHS Publication No. 1408. Single copies may be obtained free of charge from the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

Blue Shield Plan Membership, Benefits Continue Climb

Memberships and benefits of the 84 Blue Shield Plans in the United States, Puerto Rico, and Canada continued to climb during the first three months of 1966, the National Association of Blue Shield Plans announced.

Membership increased 543,170 during the first three months of 1966 to a record 58,453,324, up over 2 million from a year ago.

Benefits paid out amounted to $363,866,053, an increase of almost $29 million over last year's first quarter.

In the first quarter of 1966, 92.8 per cent of premium income was returned to subscribers in benefits, up 0.8 per cent over the first quarter of 1965.

Included in the total enrollment figure is the membership of Medical Indemnity of America, Inc., a stock company wholly owned by the National Association of Blue Shield Plans.

During the first three months of 1966, membership gains were reported by 60 Plans, 22 had losses, and two remained the same. Gains totaled 651,113 while losses amounted to 107,943.

The 0.9 per cent enrollment increase in the first three months brought Blue Shield coverage in the United States to 27.6 per cent of the population.

Blue Shield now covers 26.7 per cent of the Canadian population and 4.3 per cent of the population of Puerto Rico.

Ohioan Will Receive National Award At Occupational Health Meeting

An Ohioan will be honored with a Presidential citation at the American Medical Association Congress on Occupational Health meeting in Portland, Oregon, on September 29.

Dr. Herman J. Bearzy, director of the Department of Physical Medicine and Rehabilitation, Miami Valley Hospital, Dayton, has been selected to receive the 1965 Physician's Award of the President's Committee on Employment of the Handicapped. The award will be presented at the Oregon meeting.

The President's Award is an illuminated scroll with an appropriate inscription over the signature of the President of the United States.

Nominations are now open for the naming of a physician who has made an outstanding contribution to the welfare and employment of the handicapped workers as recipient of the 1966 Award. Nominations must be in the hands of the President's Committee by December 31, 1966.

What is believed to be one of the largest groups of LSD - related adverse reactions to date was studied by investigators at the University of California, with 70 persons treated. Report of the study was published in the August 8 issue of *The Journal of the American Medical Association.*

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References:

[1]Morrison, A. B., and Campbell, J. A., Journal of Pharmaceutical Sciences, 54, 1 (1965)

[2]Campagna, F. A., Cureton, G., Mirigian, R. A., and Nelson, E., ibid., 52, 605 (1963)

[3]Levy, G., and Hayes, B. A., New England Journal of Medicine, 262, 1053 (1960)

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Here Are Chairmen and Secretaries Of OSMA Specialty Sections

Following are names and addresses of chairmen and secretaries of the Ohio State Medical Association Specialty Sections, with some program chairmen. Most of these sections met during the OSMA Annual Meeting in Cleveland and elected or re-elected officers. Specialty Sections aid the Committee on Scientific Work to plan programs for the Annual Meeting. These names and addresses are given for the benefit of persons who may wish to correspond with Section officers in regard to program matters.

Section on Anesthesiology — Chairman, Edward Hartenian, M. D., 1236 East Rookwood Dr., Cincinnati 45208; Secretary, David M. Katchka, M. D., 3939 Monroe Street, Toledo 43606.

Section on Ear, Nose and Throat — Chairman, Stephen P. Hogg, M. D., 250 Wm. Howard Taft Rd., Cincinnati 45219, (also president, Ohio ENT Society); Secretary, Richard L. Ruggles, M. D., 10515 Carnegie Ave., Cleveland 44106, (also secretary, Ohio ENT Society).

Section on General Practice of Medicine — Chairman, William M. Wilson, M. D., 3316 Maize Road, Columbus 43224; Secretary, Glenn W. Pfister, Jr., M. D., 8040 Reading Road, Cincinnati 45237.

Section on Hospital Directors of Medical Education — Chairman, Warren G. Harding, 2nd, M. D., Grant Hospital, 309 East State St., Columbus 43215; Secretary, Lee Sataline, M. D., Toledo Hospital, North Cove Boulevard, Toledo 43606; Program Chairman, Robert V. Bachman, M. D., 14600 Detroit Road, Cleveland 44107.

Section on Internal Medicine — Chairman, Ray A. Van Ommen, M. D., 2020 East 93rd Street, Cleveland 44106; Secretary, William A. Millhon, M. D., 3545 Olentangy River Rd., Columbus 43214.

Section on Neurological Surgery — Chairman, Julius Wolkin, M. D., 10900 Carnegie Ave., Cleveland 44106, (also president, Ohio Neurosurgical Society); Secretary, John N. Meagher, M. D., 1275 Olentangy River Rd., Columbus 43214, (also secretary, Ohio Neurosurgical Society).

Section on Obstetrics and Gynecology — Chairman, Sidney Kay, M. D., 2825 Burnet Avenue, Cincinnati 45219; Secretary, Keith DeVoe, Jr., M. D., 3545 Olentangy River Road, Columbus 43214.

Section on Occupational Medicine — Chairman, Harold Imbus, M. D., 1128 Richland Terrace, Marion 43305; Secretary, Sidney I. Lerner, M. D., Kettering Laboratory, Cincinnati College of Medicine, Eden Avenue, Cincinnati 45219.

Section on Ophthalmology — Chairman, Russell J. Nicholl, M. D., 10515 Carnegie Avenue, Cleveland 44106; Secretary, William E. Sovick, M. D., 207 Mahoning Bank Bldg., Youngstown 44503.

(Section Officers — *Continued*)

Section on Pathology — Chairman, James B. McMillan, M. D., 1425 West Fairview Ave., Dayton 45406, (also president, Ohio Society of Pathologists); Secretary, L. J. McCormack, M. D., 2020 East 93rd Street, Cleveland 44106, (also secretary, Ohio Society of Pathologists).

Section on Pediatrics—Chairman, Henry F. Saunders, M. D., 2002 Warrensville Center Road, Cleveland 44121; Secretary, Malcolm L. Robbins, M. D., 4373 East Livingston Avenue, Columbus 43227.

Section on Physical Medicine and Rehabilitation — Chairman, Marvin H. Spiegel, M. D., Dodd Hall, 472 West 8th Avenue, Columbus 43210; Secretary, John L. Melvin, M. D., Dodd Hall, 472 West 8th Avenue, Columbus 43210, (also secretary, Ohio Society of PMR).

Section on Plastic Surgery — Chairman, Clifford L. Kiehn, M. D., 10605 Chester Avenue, Cleveland 44106; Secretary, H. William Porterfield, M. D., 1100 Morse Road, Columbus 43224; Program Chairman, Robin Anderson, M. D., 2020 East 93rd St., Cleveland 44106.

Section on Psychiatry and Neurology — Chairman, John A. Whieldon, M. D., 196 East State Street, Columbus 43215, (also president, Ohio Psychiatric Association); Secretary, Philip C. Rond, Jr., M. D., 130 South Davis Avenue, Columbus 43222, (also secretary, Ohio Psychiatric Association); Program Chairman, James R. Hodge, M. D., 1540 West Market Street, Akron 44313.

Section on Radiology — Chairman, Sidney W. Nelson, M. D., University Hospital, 410 West 10th Ave., Columbus 43210; Secretary, Paul A. Jones, M. D., 838 Market Street, Zanesville 43701.

Here Is Roster of Officers of Ohio Specialty Societies

Ohio Specialty Societies in many instances cooperated in sponsoring programs in connection with the Ohio State Medical Association Annual Meeting, many of them combining their programs with those of the OSMA Specialty Sections. Some organizations hold meetings at other times of the year. Following are names and addresses of officers of Specialty Societies announced to *The Journal* before this issue went to press.

Ohio Chapter, American College of Chest Physicians — President, Neil C. Andrews, M. D., 466 West Tenth Ave., Columbus 43210; Secretary-Treasurer, John H. Kennedy, M. D., Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 44109.

Ohio Ear, Nose and Throat Society — President, Stephen H. Hogg, M. D., 250 William Howard Taft

(Continued on Next Page)

(Specialty Society Officers — *Contd.*)

Rd., Cincinnati 45219, (also chairman of Section on Ear, Nose and Throat); Secretary, R. L. Ruggles, M. D., 10515 Carnegie Avenue, Cleveland 44106, (also secretary of Section on Ear, Nose and Throat).

Ohio Society of Anesthesiologists — President, William Hamelberg, M. D., Department of Anesthesiology, Ohio State University Hospital, 410 West Tenth Avenue, Columbus 43210; Secretary-Treasurer, Steven Kovacs, M. D., 17811 Lake Road, Lakewood 44107.

Ohio Society of Internal Medicine — President, Leonard P. Caccamo, M. D., 2111 Belmont Avenue, Youngstown 44505; Secretary-Treasurer, Edward O. Hahn, M. D., Westgate Medical Arts Center, Fairview Park, Cleveland 44126.

Ohio Neurosurgical Society — President, Julius Wolkin, M. D., 10900 Carnegie Avenue, Cleveland 44106, (also chairman of Section on Neurological Surgery); Secretary, John N. Meagher, M. D., 1275 Olentangy River Road, Columbus 43212, (also secretary of Section on Neurological Surgery).

Ohio Ophthalmological Society — President, Robert Willard, M. D., 3626 Monroe Street, Toledo 43606; Secretary-Treasurer, Robert H. Magnuson, M. D., 150 East Broad Street, Columbus 43215.

Ohio Society of Pathologists — President, James B. McMillan, M. D., 1425 West Fairview Ave., Dayton 45406, (also chairman of Section on Pathology); Secretary, L. J. McCormack, M. D., 2020 East 93rd Street, Cleveland 44106, (also secretary of Section on Pathology).

Ohio Chapter, American Academy of Pediatrics — President, Thomas E. Shaffer, M. D., 561 South 17th Street, Columbus 43205; Secretary-Treasurer, Lawrence C. Thompson, M. D., 120 Sturges Avenue, Mansfield 44903.

Ohio Society of Physical Medicine and Rehabilitation — President, Robert J. Gosling, M. D., 3939 Monroe Street, Toledo 43606; Secretary, John L. Melvin, M. D., 472 West 8th Ave., Dodd Hall, Columbus 43210, (also secretary of Section on Physical Medicine and Rehabilitation).

Ohio Psychiatric Association — President, John A. Whieldon, M. D., 196 East State Street, Columbus 43215, (also chairman of Section on Psychiatry and Neurology); Secretary, Philip C. Rond, Jr., M. D., 130 South Davis Avenue, Columbus 43222, (also secretary of Section on Psychiatry and Neurology); Program Chairman, James R. Hodge, M. D., 1540 West Market Street, Akron 44313; Executive Secretary, Mr. Gene P. King, 88 East Broad Street, Columbus 43215.

Ohio State Radiological Society — President, M. M. Thompson, M. D., 1544 South Byrne Road, Toledo 43614; Secretary, Mortimer Lubert, M. D., Mt. Sinai Hospital, 1800 East 185th Street, Cleveland 44106.

Ohio Committee on Trauma, American College of Surgeons — Chairman, Wesley Furste, M. D., 3545 Olentangy River Road, Columbus 43214.

National Congress on Quackery Is Scheduled in Chicago

The Third National Congress on Medical Quackery will be held October 7-8 in Chicago at the Pick-Congress Hotel.

The Congress will be sponsored by the American Medical Association and the National Health Council.

The Congress will bring together again major American groups concerned with efforts to safeguard the public against useless cures, mechanical gadgets, food fads and other quack devices and worthless treatment. The First National Congress on Medical Quackery was held in 1961 and the Second Congress was held in 1963.



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Are You Registered to Vote?...

September 28 Is Registration Deadline for Persons Who Must Qualify Themselves to Vote in November 8 General Election

NOVEMBER 8 is General Election Day, but for citizens who must register before they can vote, September 28 is an equally important date. September 28 is the final day to register. A citizen who is in doubt as to his registration status should inquire of his County Board of Elections.

Here are some facts to remember and dates to note in regard to the election as outlined by the office of the Secretary of State.

Each person voting in Ohio on November 8, 1966, will receive at least three ballots:

1. Office Type Ballot;
2. Non-Partisan Ballot;
3. Questions and Issues Ballot.

The following state, district, and county offices will appear on the Office Type Ballot: Governor, lieutenant governor, attorney general, auditor of state, secretary of state, treasurer of state, representatives to congress, state senators, state representatives, one county commissioner, and county auditor.

The Non-Partisan Ballot will contain the candidates for: two judges of the Supreme Court of Ohio, many common pleas and probate judges, judge of the Court of Appeals in some counties.

The Questions and Issues Ballot will contain any bond issues, tax levies, and miscellaneous questions and issues submitted in your political subdivision.

Important Dates

September 9 — Boards of Elections begin mailing Absent Voter Ballots to members of the armed services from whom applications have been received.

Also first day for Boards of Elections to receive applications for Absent Voter Ballots by civilians outside the United States, and to begin mailing Absent Voter Ballots to civilians outside the United States.

September 28 — Last day to register.

October 9 — First day for Boards of Elections to receive applications for disabled and civilian absent voter ballots for persons located within the United States.

Also first day of period during which votes may be cast at Boards of Elections by voters who expect to be absent from their counties and precincts on Election Day.

November 3 — Last day (ending at 4 P. M.) for voting at Boards of Elections by voters who will be absent from their counties and precincts on Election Day.

November 4 — By 12:00 noon of this date civilian absent, sick or disabled voter ballots must be delivered to clerks of Boards of Elections.

November 5 — By 12:00 noon of this date applications for Armed Service Absent Voter Ballots must be received by clerks of Boards of Elections.

November 8 — General Election Day. Polls open at 6:30 A. M. (EST) and close at 6:30 P. M. (EST).

Qualifications for Voting

You are qualified to vote if:

- You are a citizen of the U. S.
- You are at least 21 years of age or will be on the day of the next General Election (November 8, 1966).
- You have, at the time of the election, been a resident of: the state for one year; the county for 40 days; the voting precinct for 40 days.

[If you have moved from one county to another county within Ohio, or from one precint to another in the same county within 40 days before the election, you may vote in the precinct from which you moved.]

- You are registered. (This requirement applies only to persons who reside in registration territory.)

You must be registered to vote if:

You reside in registration territory. (Any city having a population of 16,000 or over, or any area which has adopted registration. Contact your County Board of Elections to determine your registration status.)

Registration in Ohio is permanent, and need not be renewed unless:

- You have not voted at least once in the past two calendar years.
- You moved since you registered.
- You have changed your name. (A woman must re-register if she has married since she registered. If married after September 28, she may vote on November 8, but not thereafter, under her former name.)

Additional information is available from County Boards of Elections as to the following:

- Voting for members of the Armed Forces and their spouses;
- Registration for members of the Armed Forces and their spouses returning home;
- Absent Voting; and
- Voting and registration for disabled voters.

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. The neomycin in Neo-Synalar Cream rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

References: 1. Kanee, B.: Canad Med Ass J 88:999 (May 18) 1963. 2. Scholtz, J. R.: Calif Med 95:224 (Oct.) 1961. 3. Jansen, G. T., Dillaha, C. J., and Honeycutt, W. M.: Arch Derm 92:283 (Sept.) 1965.

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Ohio Voices Objections to HEW. . .

President of OSMA Forwards Statement to Washington Outlining Fallacies and Discrepancies in Regulations

IN EFFORTS TO OBTAIN CHANGES in objectionable regulations established by the U. S. Department of Health, Education, and Welfare regarding Medicare, welfare programs under Title XIX of the Medicare Law, and the Civil Rights Act, the Ohio State Medical Association submitted to the House Committee on Ways and Means a prepared statement pointing out the fallacies and discrepancies in these regulations.

The text of the statement follows:

August 15, 1966

The Hon. Wilbur D. Mills, Chairman
Committee on Ways and Means
U. S. House of Representatives
Washington, D. C. 10025

Dear Chairman Mills:

It is our understanding that you currently are conducting hearings into the matter of Title XIX, Public Law 89-97. Therefore, we respectfully submit for your information and consideration certain adverse conditions resulting from the implementation of Title XIX in Ohio.

It is our conviction that the Department of Health, Education, and Welfare has, by restrictive, arbitrary and capricious regulation, created a situation that is contrary to the intent of the Committee on Ways and Means and the intent of Congress; namely, that the administration of P. L. 89-97 shall be conducted without interference in the patient-physician relationship and in the spirit of Sections 1801, 1802, and 1803.

Situation Described

Please permit me to describe this situation, point by point:

1. The Ohio Department of Public Welfare has made available to Aid for the Aged recipients an additional $3 cash a month for these individuals to use to "buy in" under Part B of the Social Security program. Approximately 90 per cent of these recipients have done so.

2. Under regulations which the Ohio Department informs us have been promulgated by HEW, the only methods by which these AFA recipients can obtain Part B payment on their behalf is (A) that the doctor accept assignment or (B) that the recipient pay the physician out of his monthly subsistence allowance and send a receipted bill to the Part B carrier.

3. The Ohio Department has adopted a policy stating that it will pay the $50 deductible but will not pay the 20 per cent deductible.

4. This Association has suggested that the physician bill the patient and the patient forward the bill to the Ohio Department of Public Welfare. The Department then would pay the bill and send a copy of the payment voucher (in effect, a receipted bill) to the Part B carrier, which would reimburse the department 80 per cent of the charges.

5. The Part B carrier in Ohio has expressed a willingness to follow this recommended procedure, but the Ohio Department of Public Welfare informs us that HEW, by regulation, will not permit the Department to do so. It states that HEW regulations give it no choice in the matter.

This situation violates Section 1801 by establishing regulatory control over the method of "* * * compensation of any * * * person providing health services."

Section 1812 (a) states that an individual, under the program, is entitled to have payment made on his behalf. It does not state that payment cannot be made to a person responsible for the medical needs of the patient, whether that person is a guardian or a state agency.

Regulations Conflict

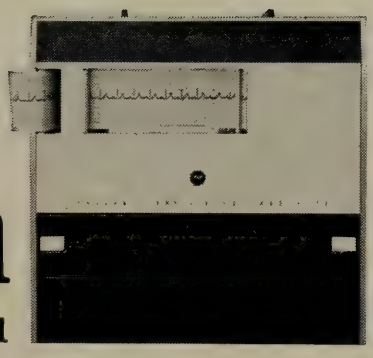
On the other hand, HEW has issued regulations that make it impossible for a State to meet the purpose of Title XIX, Section 1901, which is to enable each State to furnish medical assistance for the aged, among others.

The physician is forced to (1) accept assignment, regardless of his personal preference, or (2) require the AFA patient to reimburse him from his limited monthly cash subsistence in order to obtain a receipted bill, or (3) simply throw up his hands in disgust and abandon his efforts to cooperate in this program.

The physicians of Ohio are sincerely striving to cooperate in this program, but they cannot do so when they are forced to sacrifice their personal beliefs and their professional freedom.

The autocratic, dictatorial attitude of HEW is an insult to the intent of Congress. It has been, and

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continues to be, equally insulting to the medical profession.

For example, HEW has ordered that physicians, to be reimbursed for their professional services provided Title XIX patients, must sign an oath that they have abided and will continue to abide by the Civil Rights Act. HEW has coldly ignored our protests of this directive and has refused to recognize our Principles of Medical Ethics, particularly that section which states: "Physicians should observe ALL LAWS, uphold the dignity and honor of the profession and accept its self-imposed disciplines."

"Second-Class Citizens"

HEW has, in effect, said, "You doctors are second-class citizens. Therefore, you will have to sign a statement that you are law-abiding."

This ridiculous imposition has forced a considerable number of physicians to discontinue treatment of Title XIX patients because they refuse to be relegated to second-class citizenship.

Now we are confronted with the second situation, being these arbitrary and totally unnecessary administrative regulations HEW has promulgated under Titles XVIII and XIX, P. L. 89-97, regulations which force physicians to abandon their personal beliefs or else refuse to participate under conditions not authorized and not intended by Congress.

Still another negative development under Title XIX is Ohio's discontinuance of participating in the Mills Section of the Kerr-Mills Act, once it adopted a Title XIX program. It is our position that such participation is important because it provides financial assistance for the medically indigent in order that he not become totally indigent.

It is our sincere hope that the Committee on Ways and Means will see fit to instruct the Department of Health, Education, and Welfare (1) to withdraw these contradictory and unlawful regulations in order to permit the various State Welfare Departments to meet their responsibilities and obligations in a clear and direct manner.

HEW should be concerned with creating an atmosphere that would provide optimum communication and trust on the part of all persons and parties involved in carrying out the purposes of P. L. 89-97.

Finally, and I hope that I will not be considered presumptuous, I sincerely recommend that the Committee on Ways and Means constitute itself as a "watchdog committee" to supervise closely the future Medicare regulations and operations of the Department of Health, Education, and Welfare in order that the administration of P. L. 89-97 be carried out within the intent and the spirit of Congress.

Respectfully,

(Signed) L. C. MEREDITH, M. D.
President
Ohio State Medical Association

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Disaster Institute Program . . .

Planning for Management of Mass Medical Emergencies To Be Theme at Columbus Meeting, Sunday, October 30

A Diaster Institute Program is scheduled in Columbus on Sunday, October 30, for all persons interested in the specific theme "Planning for the Management of Mass Medical Emergencies." Sponsoring organizations are the Ohio State Medical Association, the Ohio Hospital Association, Ohio Department of Health, the Ohio Osteopathic Association of Physicians and Surgeons, the American Red Cross, and the Ohio Civil Defense Service.

Place is the Neil House, downtown Columbus hotel, with registration opening at 8:00 A. M. and the first program feature at 9:30. Adjournment time is 4:00 P. M. The program has been announced as follows:

Morning Session

Registration

Greetings

William Slabodnick, President, Ohio Hospital Association, Administrator, Fisher-Titus Memorial Hospital, Norwalk

Introduction and Setting the Theme

Roger Marquand, Chairman, Ohio Hospital Association Disaster Preparedness Planning Committee, Administrator, Polyclinic Hospital, Cleveland

"My Organization's Role in Disaster Management"

Medicine

Lawrence C. Meredith, M. D., President, Ohio State Medical Association, Elyria

Civil Defense

Dr. Alfred E. Diamond, Ohio Civil Defense, Columbus

Hospitals

James O. Helland, Administrator, Defiance Hospital, Defiance

Red Cross

Alfred L. Baron, Executive Director, Franklin County Chapter of Red Cross

Ohio Department of Health

Albert E. Dyckes, Chief, Division of Administration

Ohio Department of Public Welfare

Robert B. Canary, Assistant Director, Ohio Department of Public Welfare

"What Are the Problems?"

Keynoter

Roger Marquand will be noting that speakers to follow will be talking on disasters which could occur in Ohio (i. e. Tornado or plant explosion).

Jackson, Mississippi Tornado

C. E. Wallace, M. D., Chairman, Disaster Planning Committee, Central Medical Society, Jackson, Mississippi

Mr. Richard H. Malone, Administrator, Hinds General Hospital, Jackson, Mississippi

Morning Break

DuPont Explosion, Louisville, Kentucky

William Rumage, M. D., Member, Committee on Disaster Medical Care, American Medical Association, Chicago

"Here's How Your Problems Can Be Solved"

Communications

Lt. William H. Hildebrand, Asst. Director of Civil Defense, Alameda, California

Transportation

Franklin V. Wade, M. D., F. A. C. S., Chief, Section for the Surgery of Trauma, Hurley Hospital; Chairman, Committee on Trauma, American College of Surgeons, Flint, Michigan

Medical Authority

Francis C. Jackson, M. D., F. A. C. S., Chief Surgeon, Veterans Administration Hospital, Pittsburgh, Pennsylvania; Chairman, Committee on Disaster Medical Care, American Medical Association

Lunch and Exhibit Break

Four Workshops

(Faculty will rotate every half hour)

How One Committee Does it

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For additional information and registration forms, contact W. Michael Traphagan, Secretary, Committee on Disaster Medical Care, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

Ohio Academy of General Practice Reports Election of Officers

Dr. Benjamin W. Gilliotte, Zanesville, was installed as president of the Ohio Academy of General Practice at that organization's Annual Scientific Assembly in Columbus, August 2-4. He succeeded Dr. William P. Smith, Jr., of Columbus.

The statewide organization of general practitioners held its Scientific Assembly and business meeting at the Sheraton-Columbus Motor Hotel in downtown Columbus. Governor James A. Rhodes paid special honor to the organization's meeting by declaring the period Family Doctor Week in Ohio.

Other new officers installed at the meeting were Drs. B. L. Huffman, Jr., Toledo, president-elect; Charles H. Jobe, Cleveland, vice-president; George Clouse, Columbus, treasurer; Fred V. Light, Cleveland, speaker of the House of Delegates; Dr. Sanford Press, Steubenville, vice-speaker of House of Delegates; Raymond M. Kahn, Dayton, AAGP Delegate; and William P. Smith, Jr., Columbus, AAGP Alternate.

Newly elected directors are Drs. William J. Lewis, Dayton; L. W. Siberd, Toledo; Harry A. Killian, Willoughby; H. Judson Reamy, Dover; Edward A. Carlin, Newark; and Thomas M. Hughes, Columbus.

Fertility Control Film Available For Medical Group Showing

"Fertility Control and the Physician" is the name of a film in two parts available for showing to professional groups. The film is designed for a broad scientific audience, particularly students and graduates in medicine and public health. Its purpose is to stimulate discussion of the crucial role that the health professions play in helping individual families and nations cope with rapid global population growth. The film is in two parts; Part I running 20 minutes and Part II, 24 minutes.

The film may be ordered for showing from: Planned Parenthood - World Population Film Library, 267 West 25th Street, New York, N. Y. 10001.

Drug Manufacturing Company Announces New Product Identification Code

Eli Lilly and Company recently announced the development of Identi-Code, trademark name for a new system of drug identification. The code consists of one letter and two numbers, the letter designating the product form and the numbers indicating product name and formula.

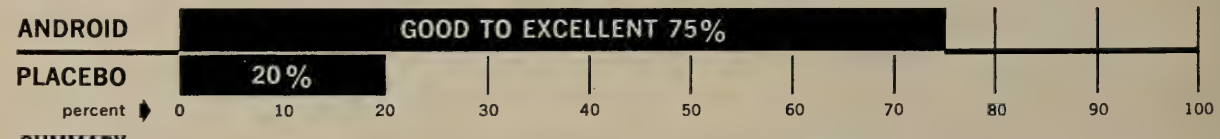
The system was announced at the recent Annual Convention of the American Medical Association in Chicago, and by special mailing to physicians. Further announcement has been made through the pages of *The Journal.*

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2. Excellent to good results, 75% with Android, 20% with Placebo.
3. Cites synergism between androgen and thyroid.
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6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"*Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS — Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease, hyperthyroidism. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Thiamine HCL ..... 10 mg.
Dose: 1 tablet 3 times daily.
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Bottles of 100, 500, 1,000.

ANDROID-X NEW
Each orange tablet contains:
Methyl Testosterone ..... 12.5 mg.
Thyroid Ext. (1 gr.) ..... 64 mg.
Glutamic Acid ..... 50 mg.
Thiamine HCL ..... 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

ANDROID-PLUS
Each white tablet contains:
Methyl Testosterone ..... 2.5 mg.
Thyroid Ext. (¼ gr.) ..... 15 mg.
Thiamine HCL ..... 25 mg.
Ascorbic Acid (Vit. C) ..... 250 mg.
Glutamic Acid ..... 100 mg.
Pyridoxine HCL ..... 5 mg.
Niacinamide ..... 75 mg.
Calcium Pantothenate ..... 10 mg.
Vitamin B-12 ..... 2.5 mcg.
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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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Sixth District Postgraduate Day Scheduled in Akron, Oct. 19

The Sixth Councilor District Postgraduate Day clinical sessions, comprised of nationally renowned medical educators will be held at the Sheraton-Mayflower Hotel in Akron, on Wednesday, October 19. Registration will be from 8:30 to 9:30 A.M. on the first floor of the hotel, and the remainder of the program will be conducted completely on one floor. Cost of registration will include luncheon and parking facilities.

Advance registration is being arranged via a mailing of programs and advance registration cards to members of the Sixth Councilor District. The program has been announced as follows:

9:40-10:30 A. M.

Inguinal Hernia, Dr. Chester B. McVay, clinical professor of surgery, University of South Dakota — Cincinnati Room;

Heart Failure, Dr. James V. Warren, professor and chairman, Department of Medicine, Ohio State University School of Medicine — Ballroom;

Pediatric Panel, Dr. Morris Green, associate professor of pediatrics, Indiana University Medical Center; Dr. Ernest K. Cotton, assistant professor of pediatrics, University of Colorado Medical School; Dr. Robert H. Parrott, director, Childrens Hospital, Washington, D. C. and clinical professor of pediatrics, George Washington University — Ohio Room;

10:40-11:30 A. M.

Amniocentesis for Prediction of Erythroblastosis Fetalis, Dr. Richard W. Stander, associate professor, Department of Obstetrics and Gynecology, Indiana University Medical Center — Cincinnati Room;

Medical Surgical Panel, Dr. McVay; Dr. Edmund B. Flink, professor of medicine and chairman of Department of Medicine, West Virginia School of Medicine; Dr. Roger B. Hickler, assistant professor of medicine and director of Hypertension Laboratory, Peter Bent Brigham Hospital; Dr. Lester Dragsted, research professor of surgery, University of Florida; Dr. James V. Warren, professor and chairman, Department of Medicine, Ohio State School of Medicine; Dr. Desiderius Emerick Szilagyi, head, Division of General Surgery, Henry Ford Hospital—Ballroom.

Behavorial Problems of Childhood, Dr. Cotton — Ohio Room.

11:40-12:30 P. M.

High Risk Obstetrics, Robert E. L. Nesbitt, Jr., professor and chairman, Department of Obstetrics and Gynecology, College of Medicine, State University of New York, Upstate Medical Center — Cincinnati Room;

Duodenal Ulcer, Dr. Dragsted — Ballroom;

(Sixth District — *Contd.*)

Respiratory Distress Syndrome in Newborn, Dr. Cotton — Ohio Room.

12:40-2:00 P. M. — Luncheon - Ballroom

2:10-3:00 P. M.

Endometriosis, Dr. Carl T. Javert, professor, clinical obstetrics and gynecology, Columbia University — Cincinnati Room;

Diagnosis, Treatment and Prevention of Viral Diseases, Dr. Parrott — Ballroom;

Renin and Aldosterone Relationships in Hypertension, Dr. Hickler — Ohio Room.

3:10-4:00 P. M.

Abortion — Body Types — Emotional Factors — Preventive Drugs — Long-Term Counseling, Dr. Javert and Dr. Richard W. Stander—Cincinnati Room.

Vascular Surgery, Dr. Szilagyi — Ballroom;

Theoretical and Practical Considerations of Magnesium Deficiency in Man, Dr. Flink — Ohio Room.

National Rheumatism Program Scheduled in Cincinnati

Preliminary announcement has been made of the American Rheumatism Association's 12th Interim Session to be held in Cincinnati on December 2 and 3. Meeting place is the Netherland-Hilton Hotel.

Deadline for abstracts of presentations offered for this program is September 15. Abstracts should be mailed to: Carl M. Pearson, M. D., University of California Medical Center, Los Angeles, Calif., 90024.

Additional information may be obtained from Robert M. Lincoln, The Arthritis Foundation, Ohio Valley Chapter, 2400 Reading Rd., Cincinnati, 45202.

Lectures on Human Reproduction Are Scheduled in Cleveland

The Institute for the Study of Human Reproduction invites physicians to attend a non-tuition series of courses scheduled in Cleveland under the title "I. S. H. R. Reviews." Programs are scheduled on Wednesdays from 2 to 4 p. m. in the Conference Room of Saint Ann Hospital, Cleveland.

The Institute, in association with The Saint Ann Hospital, will present Lecture Series No. 5, entitled "New Horizons in Reproductive Physiology and Pathology, November 7-9, in the Academy of Medicine of Cleveland facilities, 10525 Carnegie Avenue, from 5 to 8 p. m. on the three days.

Topics and speakers for the weekly series of programs in September are as follows:

September 7 — "The Cell as a Mirror of Disease," James W. Reagan, M. D., professor of pathology at Western Reserve University.

September 14 — "Prenatal Drug Effects on Offspring," Joseph M. Ordy, Ph. D., instructor in sur-

(Continued on Next Page)

(Human Reproduction — *Contd.*)

gery at Western Reserve and research associate at the Cleveland Psychiatric Institute.

September 21 — "Illegitimacy: A Socio-Psychiatric Problem," L. Douglas Lenkoski, M. D., acting director of the Department of Psychiatry at Western Reserve.

September 28 — "LSD and History," Albert Sattin, M. D., Departments of Pharmacology and Psychiatry, Western Reserve.

Watch for additional information on these programs in coming issues of *The Journal.* Details may be obtained from Miss Barbara A. Kasprow, Registrar, Institute for the Study of Human Reproduction, Saint Ann Hospital, 2475 East Blvd., Cleveland 44120.

Physicians in State Mental Hygiene Schedule Program October 14

The Association of Physicians of the Department of Mental Hygiene and Correction of the State of Ohio will meet on October 14 at the Columbus State School, Columbus. Joining them will be the Association of Directors of Out-Patient Clinics of the Department.

Dr. Rudolph A. Buki, president, will present Dr. Judith Rettig, superintendent of Columbus State School, who will welcome the Associations. "The Community Service Unit" will be the subject of the paper of Dr. Abdon E. Villalba following which a business meeting will be held prior to lunch.

Dr. Julius Nemeth, in the afternoon, will present a paper, coauthored by Dr. M. Petrovich on "Four Years of Clinical Experience with combined Chlorpromazine and Trifluoperazine Treatment."

Guest and principal speaker will be Dr. William Grater, clinical assistant professor of allergy in the Southwestern Medical School, Dallas, Texas, who will address the session on "Common Sense in Drug Allergy."

American College of Physicians Postgraduate Courses, 1966

The American College of Physicians has released a list of postgraduate courses to be given in various areas of the country. Details on these programs may be obtained by writing to the college at 4200 Pine Street, Philadelphia, Pa. 19104. Following are courses scheduled in the near future:

September 28 - October 1 — Advances in Cutaneous Medicine for Internists, Rochester, Minn.

October 3 - 7 — The Care of the Critically Ill Medical Patient, Syracuse, N. Y.

November 7 - 11 — Endocrine and Metabolic Disorders, Brooklyn, N. Y.

November 14 - 18 — Newer Aspects of Experimental and Clinical Allergy, Boston, Mass.

November 28 - December 2 — Progress in Gastroenterology—1966, Philadelphia, Pa.

December 5 - 9 — What the Internist Should Know About Cancer, New York City.

December 14 - 17—Infectious Diseases, Pittsburgh, Pennsylvania.

New Ways to Teach Nursing Promoted by PHS Grant

TV programs, movies, self-teaching textbooks, and other instruction aids will be produced by Western Reserve University's Frances Payne Bolton School of Nursing in an experimental project to develop more effective ways to teach the techniques of nursing.

The project, beginning in September and extending over five years, has been made possible by a grant of $266,032 from the United States Public Health Service. USPHS funds for this purpose were provided by Congress in the Nurses Training Act of 1964, designed "to improve nursing."



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References on request

Obituaries

Ad Astra

George Steele Bowers, Sr., M.D., Toledo; Medical College of Virginia, 1935; aged 56; died July 18; member of the Ohio State Medical Association, the American Medical Association, the American Thoracic Society; fellow of the American College of Chest Physicians. A practicing physician in Toledo for 20 years, Dr. Bowers specialized in treating diseases of the chest, and was a past president of the local tuberculosis societies. From 1941 to 1946 he served with the Army Medical Corps and attained the rank of lieutenant colonel. Survivors include two daughters, two sons, his mother, three sisters, and two brothers.

Henry Howard Bowman, M. D., Canton; Ohio Medical University, Columbus, 1907; aged 84; died July 12; member of the Ohio State Medical Association and the American Medical Association; past president of the Canton Academy of Medicine. A native of Stark County, Dr. Bowman practiced for some 59 years in the Canton area. Among affiliations, he was a member of the Presbyterian Church and of the Masonic Lodge. Survivors include two daughters and his son, Dr. Harold J. Bowman, also of Canton.

Joseph George Brady, M. D., Naples, Fla.; Western Reserve University School of Medicine, 1919; aged 72; died July 15 in a boating accident; member of the Ohio State Medical Association and the American Medical Association. A Cleveland physician for many years before his retirement in 1960, Dr. Brady was medical director of the American Bureau of Analysis in downtown Cleveland, and was physician also for a number of industrial firms. Among survivors are his widow, three sons and a sister.

Richard Edmund Burdsall, M. D., Seven Mile; Medical College of Ohio, Cincinnati, 1901; aged 93; died July 9; member of the Ohio State Medical Association and the American Medical Association. A native of Southwestern Ohio, Dr. Burdsall devoted a lifetime to practice in the Seven Mile and Collinsville area of Butler County. He was a member of the Knights of Pythias and an elder in the Presbyterian Church. Surviving are his widow, two daughters, a son, and a half-brother.

Alto E. Feller, M. D., Charlottesville, Va.; State University of Iowa College of Medicine, 1933; aged 56; died July 4; former member of the Ohio State Medical Association. A former faculty member at Western Reserve University School of Medicine where he was assistant professor of preventive medicine, Dr. Feller was more recently associate dean of medicine at the University of Virginia.

Ernest Henry Ferrell, Jr., M. D., New Haven, Conn.; Western Reserve University School of Medicine, 1947; aged 42; died July 14. Dr. Ferrell left Ohio shortly after finishing his medical schooling, and had been practicing surgery in New Haven. He leaves his widow, three sons, his father, and a brother.

Kenneth Russel Howard, M. D., Sylvania; University of Cincinnati College of Medicine, 1924; aged 66; died July 14; member of the Ohio State Medical Association, the American Medical Association, Industrial Medical Association, and the American Society of Abdominal Surgeons. A lifelong resident of Lucas County, Dr. Howard was medical director of the Owens-Illinois Libbey Products Division for 42 years. During World War II he served with the Army Air Corps medical unit and attained the rank of lieutenant colonel. His widow and a brother survive.

Merritt Stanley Huber, M. D., Bettsville; University of Louisville School of Medicine, 1934; aged 62; died July 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Huber practiced for two years at Pemberville, then went to Bettsville where he completed 30 years of practice. He served as a member of the Seneca County Board of Health and for a number of years was president of that group. During the war he was county health commissioner, and for four terms was on the local village council. A member of the Catholic Church, he is survived by his widow and a son.

Paul Zedock King, M. D., Bedford; Rush Medical College, 1936; aged 72; died July 24; member of the Ohio State Medical Association and the American Medical Association. A native of Chardon, Dr. King practiced for some 30 years in the Greater Cleveland area. During World War I he was a member of the famous Lakeside Unit, the first American medical group to serve in France. His widow and a brother survive.

John Adam Knapp, M. D., London; University of Wisconsin Medical School, 1933; aged 62; died July 1; member of the Ohio State Medical Association and the American Medical Association. A general practitioner in the London area since 1934, Dr. Knapp was a veteran of World War II. Among affili-

ations, he was a member of the Catholic Church and of the Knights of Columbus. His widow survives.

David Franklin Leach, M. D., Youngstown; Western Reserve University School of Medicine, 1939; aged 52; died July 13; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician for about ten years in Youngstown, Dr. Leach formerly practiced in Bellaire and in Beaver, Pa. Among affiliations, he was a member of the Christian Church. His mother with whom he made his home survives.

Alfred Parsons Magness, M. D., Coshocton; Ohio State University College of Medicine, 1916; aged 75; died July 31 in a traffic accident; member of the Ohio State Medical Association and the American Medical Association. Dr. Magness was a physician of long standing in the Coshocton area, having moved there in 1922. Among professional activities he was physician for the Pennsylvania Railroad in his area. He was a member of the American Legion, having served in the Navy during World War I. Other affiliations include membership in the Presbyterian Church and the Masonic Lodge. Mrs. Magness died with her husband in the accident. Surviving are two daughters and two sons, Dr. Alfred H. Magness, also of Coshocton, and Dr. John L. Magness, Fargo, N. D.

Tilman H. McLaughlin, M. D., Illinois Medical College, 1903; aged 90; died July 23. A practicing physician in Toledo many years ago, Dr. McLaughlin moved to California in 1921. Two daughters survive.

Paul David Meyer, M. D., Columbus; Ohio State University College of Medicine, 1935; aged 57; died July 15; member of the Ohio State Medical Association, the American Medical Association, Radiological Society of North America, and a Fellow of the American College of Radiology; diplomate of the American Board of Radiology. Dr. Meyer was head of the X-ray Department at Grant Hospital and assistant professor of radiology at Ohio State University College of Medicine. He was past president of both the Central Ohio and Ohio State Radiological Societies and was affiliated with numerous other professional organizations. He was a major in the Army Medical Corps, was a member of the Jewish Center board, former member of the United Jewish Fund, a member of B'nai B'rith, and a past president of the American Jewish Physicians Committee. Survivors include his widow; two sons, Dr. Teale L. Meyer, Cincinnati, and Dr. Bruce P. Meyer, Dallas, Texas; also a brother, Dr. Jerome Meyer, of Dayton.

Edmund C. Mohr, M. D., Toledo; University of Michigan Medical School, 1916; aged 74; died July 10; member of the Ohio State Medical Association, the American Medical Association, Central Association of Obstetricians and Gynecologists; fellow of the American College of Obstetricians and Gynecologists,

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Elmer Herman Nagel, M. D., Youngstown; Ohio State University College of Medicine, 1916; aged 79; died July 6; member of the Ohio State Medical Association and the American Medical Association; past president of the Mahoning County Medical Society. Only recently Dr. Nagel was honored for completing 50 years of devotion to the practice of medicine, with virtually all of that time served in the Youngstown area. For a period during World War I he served with the Army Medical Corps. He was a member of the Catholic Church, the American Legion, Maennerchor, and the Elks Lodge. Survivors include his widow, a son, a daughter, a brother and two sisters.

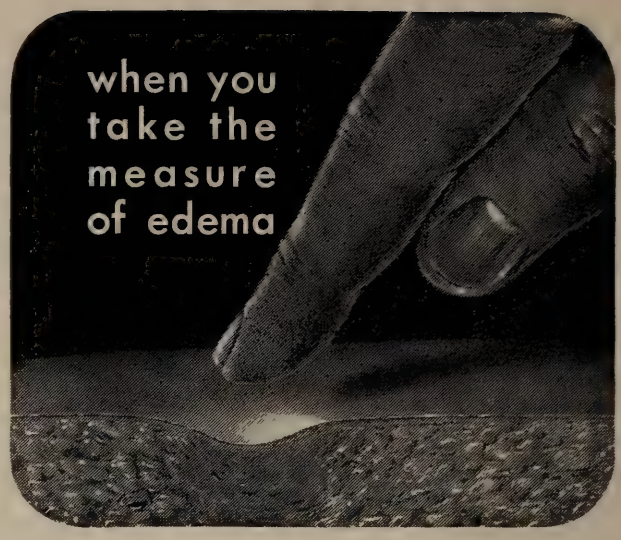
Josiah Merton Pumphrey, M. D., Mt. Vernon; Jefferson Medical College of Philadelphia, 1904; aged 87; died July 23; member of the Ohio State Medical Association and the American Medical Association; past president of the Knox County Medical Society. A native of Mt. Vernon, Dr. Pumphrey devoted most of his professional career to practice in that area. He was a veteran of World War I and formerly active in the Ohio National Guard. He was a member of the American Legion, Chamber of Commerce, Elks Lodge, the Christian Church, and several Masonic bodies. Dr. Gordon H. Pumphrey, also of Mt. Vernon, is a son. Other survivors include a daughter and a sister.

Daniel S. Quickel, M. D., Anderson, Indiana; Cincinnati College of Medicine and Surgery, 1894; aged 98; died April 19. An alumnus of an Ohio medical college, Dr. Quickel established his practice early in the Anderson community, according to available records.

David John Roberts, M. D., Akron; Cornell University Medical College, 1933; aged 59; died May 27; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and American Society of Abdominal Surgeons. A practitioner of many years standing in Akron, Dr. Roberts was a veteran of World War II, having served in the Air Force as a medical officer. His widow and three children survive.

William Thomas Shriner, M. D., Cincinnati; University of Cincinnati College of Medicine, 1930; aged 60; died July 7; former member of the Ohio State Medical Association. Dr. Shriner retired from practice some years ago for health reasons.

Ezra Israel Silver, M. D., Cleveland; Wayne State University College of Medicine, 1934; aged 57; died July 23; member of the Ohio State Medical Association and the American Academy of General Practice. A native of Cleveland, Dr. Silver practiced there for 32 years. He was a member of the Temple, a past master in the Masonic Lodge, past president in B'nai



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DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chlorureticand diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

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DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d: or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations,should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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B'rith; active in the Big Brothers organization and the Odd Fellows lodge. During World War II he served overseas in the Medical Corps as a lieutenant colonel. Survivors include his widow, a daughter, a son, two brothers and a sister.

Orlow Chapin Snyder, M. D., Polk; University of Michigan Medical School, 1915; aged 76; died February 16. A former resident of New York, Dr. Snyder was living in retirement.

Benjamin William Spero, M. D., Cleveland; Western Reserve University School of Medicine, 1911; aged 76; died July 12; former member of the Ohio State Medical Association. Dr. Spero practiced for many years in Cleveland, specializing in dermatology. He was a member of the Temple. Survivors include a son, two daughters, four sisters, and a brother.

Frederick W. Trinkle, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1917; aged 72; died July 28; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A resident of the Clifton area, Dr. Trinkle practiced for approximately a half century. Among affiliations, he was active in a number of Masonic bodies. Survivors include a daughter, a brother, and two sisters.

Beulah Wells, M. D., Chautauqua, N. Y.; Johns Hopkins University School of Medicine, 1922; aged 80; died July 7; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A practitioner in Cleveland for a number of years before her retirement in 1958, Dr. Wells was former head of the pediatrics department at Woman's Hospital. A brother survives.

John F. Zielinski, M. D., Lorain; Stritch School of Medicine of Loyola University, 1932; aged 57; died July 4; member of the Ohio State Medical Association and the American Medical Association. A resident of Lorain since 1940, Dr. Zielinski was medical director of the Brush Beryllium Company in Cleveland. He was a member of the Catholic Church. Surviving are his widow and three sons.

CORRECTION

In the obituary of Eugene R. Hammersley, M. D., of Tuscarawas, in last month's issue, *The Journal* erroneously omitted the widow from the list of survivors. The staff apologies for this omission and for any embarrassment it may have caused relatives and friends. Mrs. Hammersley who survives her husband helped Dr. Hammersley in his practice for many years by working in the office.

Activities of County Societies . . .

COSHOCTON

Dr. Milton A. Boyd, who practiced internal medicine in Coshocton since 1958, accepted a position at St. Marys Hospital, Richmond, Va., effective July 1.

Dr. Jose Louis Becerra opened an office in Warsaw, in Coshocton County, August 1. He formerly practiced in Middlefield. Dr. Becerra is a graduate of the National Autonomous Medical School of the University of Mexico, 1948. He interned at General Hospital, Mexico City, and was licensed to practice in Ohio, August, 1961.

CUYAHOGA

The annual golf tournament of the Academy of Medicine of Cleveland was held at Shaker Heights Country Club on July 18. About 120 golfers played the course and enjoyed the club facilities. Results were published in the August issue of *The Bulletin.*

MAHONING

The Mahoning County Medical Society is continuing its weekly participation in "Diagnosis," the radio program broadcast over WFMJ at 8:05 P. M. each Tuesday.

On broadcasts for July were the following topics and speakers: Food Poisoning — Sidney Franklin, M. D., J. R. Gillis, M. D., and George Canatsey, Ph. D., Heat Exhaustion and Stroke — G. E. DeCicco, M. D., and John J. McDonough, M. D.; Hospital Emergency Room — P. G. Giber, M. D., and F. W. Morrison, M. D.

The Mahoning County Medical Society cooperated with sponsors of the Red Cross First Aid Station at the Canfield Fair in Mahoning County. At the early September fair, persons manning the Red Cross First Aid Station served in shifts during the five day affair.

Ohioans on Program of International Medical History Congress

Two Ohio physicians were on the program for the 20th International Congress on Medical History, held in Berlin, August 22-27.

Dr. Bruno Gebhard, retired director of the Museum of Health Education, Cleveland, was one of ten delegates from the United States, and was listed on the program as lecturing on the topic, "Alfred Grotjahn's Social Pathology and the Development of Social Medicine."

Dr. Harold Feil, Cleveland Heights, was listed as lecturing on the "History of Poetry Concerning the Foxglove."

Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

IT'S ALMOST HERE AGAIN — Fall Conference time. This year the workshop scene is set for October 11 and 12, in Columbus, at Stouffer's University Inn. It will have a bit of a New Look and it is hoped that county auxiliaries will be well represented — as they most certainly should be! Mrs. Paul Sauvageot, state president-elect, has coined a new Conference slogan: "**At least** four from every auxiliary" . . . It is wise to remember that Fall Conference time is Practical Assistance time.

Four people in particular have worked long and hard to set up this important meeting: Mrs. James Wychgel, state president; Mrs. Sauvageot; Mrs. Roscoe J. Kennedy, Fall Conference chairman; and Mrs. Joseph Kaplan, cochairman. Along with them on the working staff are Mrs. James Gavin, Conference treasurer; Mrs. Fred Kelly, assistant treasurer; every state officer and board member; and helpers from Columbiana, Franklin, Huron, and Medina counties.

Registration is the morning of Tuesday, October 11, between 9:00 and 11:30 A. M. The opening luncheon at noon will be primarily to get acquainted and to set the pattern for a smooth conference. District directors will be on hand at least 30 minutes before the luncheon to see that people from the various counties are introduced to each other. Three sessions — those on International Health, Mental Health, Credits and Awards — will run simultaneously, each leader presenting her material three times. Persons attending will be divided into Groups A, B and C, each of which will hear all three subjects. The groups will not move — program leaders will go from room to room. The word is that there will be no long talks. Leaders will give enough background to set the stage, but what is particularly wanted is audience participation: the opportunity to ask questions, get answers and—yes—even criticize!

An elective sesison that afternoon of October 11 should be one to which everyone will want to flock: Parliamentary Procedures (under the leadership of Mrs. Rudolf Cooks). I don't know of anything that is more difficult to master (or more frustrating at times as well as bewildering)! You may **think** you know all there is to know about Parliamentary Procedures — but you'd better attend this session and find out how much, amazingly, you DON'T know . . .

The dinner that night will run toward the general New Look by **not** having a speaker. Instead there will be a program of entertainment, followed by the showing of films that local groups will find especially adapted to their use. Also that night, the Exhibits Section will be open where materials will be available and further questions may be asked. The exhibits will, of course, cover the various phases of Auxiliary work and will be manned by the different chairmen. Again quoting Ludel Sauvageot, "the exhibits will tell a story."

The morning of October 12 (9:00 A. M.) will feature an hour-long "sample program" on Health and Charm as presented by Summit County. There will also be a question and answer period. At 10:15 A. M., Mrs. Harry L. Fry, legislative chairman, will come up with a "sample" Political Action program which should be a "must" for every auxiliary member attending the Conference. It will effectively cue you in on what you can do back home. The September *Auxiliary News* will contain detailed information on the Conference. I'm only hitting the high spots. One last word — to members-at-large: PLEASE come. Your state officers want very much to greet you, see you, know you, help you.

Around the State

These are delayed news items that had to make way for the Convention story and the Pre-Election Conference. And now — at long last:

In May, the **Butler** Auxiliary held its last meeting of the auxiliary year with the president, Mrs. Richard Mense, presiding. This is the 25th anniversary of the Butler group, and the second president, Mrs. C. F. Macready, was introduced to the members. Mrs. Mense in reviewing the highlights of the year spoke of the annual Health Careers Day with over 300 high school students participating, the *Today's Health* magazine that is sent to all schools as well as rest homes in the area, the 21 barrels of medicine sent to World Medical Relief, the awarding of the seventh Health Careers scholarships to a high school senior. These officers were elected and installed for 1966-67: Mrs. Paul Woodward, Jr., president; Mrs. William Crawford, vice-president; Mrs. Louis Skimming, recording secretary; Mrs. Jerry Hammond, corresponding secretary; Mrs. Marvin Max, treasurer; Mrs. Carl Leyrer, director, and Mrs. Everett Jung, president-elect.

Columbiana members were invited to be guests of the County Medical Society at a dinner held at the Wick Hotel in Lisbon. Dr. and Mrs. C. W. Dewalt showed films of their 72 day trip through Africa. The Columbiana group lent assistance to the Camp Fire Girls of the area's County School for Retarded Children in their camping activities. A craft day was scheduled and the children were instructed in the making of clown puppet dolls. Mrs. J.

Lauva and daughter Inez; Mrs. William Horger; Mrs. H. F. Banfield and daughter Debbie; Mrs. R. J. Bonistalli and daughter Margaret served on the teaching staff. A party was also given on the closing day. And these women in the Columbiana auxiliary certainly believe in an early start: Three "coffees" were held for advanced showing of Christmas cards sold on behalf of AMA-ERF (this happened in June; an 8 per cent discount is given by the card company). The "coffees" were held by Mrs. R. J. Bonistalli in East Liverpool, Mrs. R. J. McConnor in Salem and Mrs. W. A. Bacon in Lisbon.

Half-Page Spread

If any auxiliary wants a practical lesson in publicity, I suggest contacting the **Hamilton** auxiliary! This group certainly seems to have succeeded in convincing the newspaper people in Cincinnati of the importance of the work of doctors' wives. On July 19, the *Cincinnati Enquirer* devoted a half-page spread by the Women's Club editor whose lead said "summer doesn't mean a recess of the volunteer work of members of the Woman's Auxiliary . . ." The story was detailed and good, and there were three excellent photographs to boot. This isn't the first time that there has been outstanding feature coverage in the local papers. It happens again and again!

Mrs. Ben I. Friedman is the new president. Mrs. Joseph E. Ghory is president-elect; Mrs. Ralph H. Miller, vice-president; Mrs. Robert E. Johnstone, treasurer; Mrs. Emil I. Barrows and Mrs. Mitchell Ede, secretaries. At the May meeting, members and guests boarded the Jubilee for a boat ride and luncheon. A program of folk music was presented by the Medi-Chords, an instrumental combo of eight physicians (how about that!) and by the Choral Group of the auxiliary.

The **Huron** auxiliary recently completed a survey of the health facilities in its county. The idea for this survey was brought to the group's attention by the local Health Department with the backing of the County Health Commissioners and was done under the auspices of the Department of Rural Sociology of Ohio State University. The survey included hospitals and their facilities, nursing homes, professional personnel, clinics and health services, voluntary agencies in the health field, school health programs, public health and welfare services and a breakdown of the health insurance coverage.

Mrs. Robert Sylvester is the new president of the **Licking** auxiliary. Serving with her are: Mrs. Charles F. Sinsbaugh, president-elect; Mrs. James H. Johnson, vice-president; Mrs. J. F. Barker, treasurer and Mrs. John Hauser, secretary. The group's late spring meeting was a dinner at the Moundbuilders Country Club, with Mrs. Lawrence Miller presiding. Three recent recipients of the group's nursing scholarships were introduced: Marcia Smith, Benita Moore and Mona Phillips.

Looking Back

A few months ago the **Lucas** County auxiliary traveled back 25 years via the magic wands of Mrs. E. Benjamin Gillette, Mrs. Gregor Sido and Mrs. Ward Jenkins. To quote from one account: "These women served as archeologists excavating interesting facts of the past 25 years." Also at this occasion called "Something Special in Silver," past presidents as well as the three state presidents from Lucas County were honored and new officers were installed. Mrs. Richard L. Schafer is the 1966-67 president; Mrs. Howard Smith, president-elect; Mrs. Ronald Wade and Mrs. James Roberts were chairmen of the 25th anniversary luncheon.

Also in May, prizes were awarded at the Bridge Marathon finale. Winners were Mrs. Henry Brunsting and Mrs. A. J. Kuehn. Runners-up were Mrs. Paul Geiger and Mrs. John Brunner. The Lucas County women hope to double participation in the Bridge Marathon this auxiliary year when proceeds will again go toward AMA-ERF and the Hospital Ship *Hope*. And talking of elections — one of Lucas County's very own members — Jane Kuebbeler — is running for Congress! She is at present a city councilwoman. (Remember what former Vice-President Richard Nixon said about doctors' wives and politics?)

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Grants Promote Research

Two new grants, totaling $50,737 have been received by the Ohio State University College of Medicine from the National Institutes of Health.

Dr. Francis E. Cuppage, Department of Pathology, was awarded $15,992 to support his studies to delineate the pathogenesis and pathophysiology of the regenerative or reparative phase of acute renal tubular injury.

Dr. Robert McCluer, Department of Psychiatry, was granted $34,745 for investigation of the isolation and characterization of the various functional and molecular species of brain RNA.

Advance notice has been given of a National Congress on Environmental Health Management to be conducted by the American Medical Association in New York City, April 24-26, 1967, at the Hotel Americana. Additional information may be obtained from James G. Telfer, M. D., director of the AMA Department of Environmental Health.

Albany Medical College is sponsoring its eighth Medical Seminar Cruise, January 6-23, 1967 — New York to the Carribbean area and return. Persons interested may write to the college at Albany, N. Y. 12208.

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Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Display classified, $1.00 per line. (12 lines to the inch) Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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The OHIO STATE MEDICAL Journal

VOL. 62 OCTOBER, 1966 NO. 10

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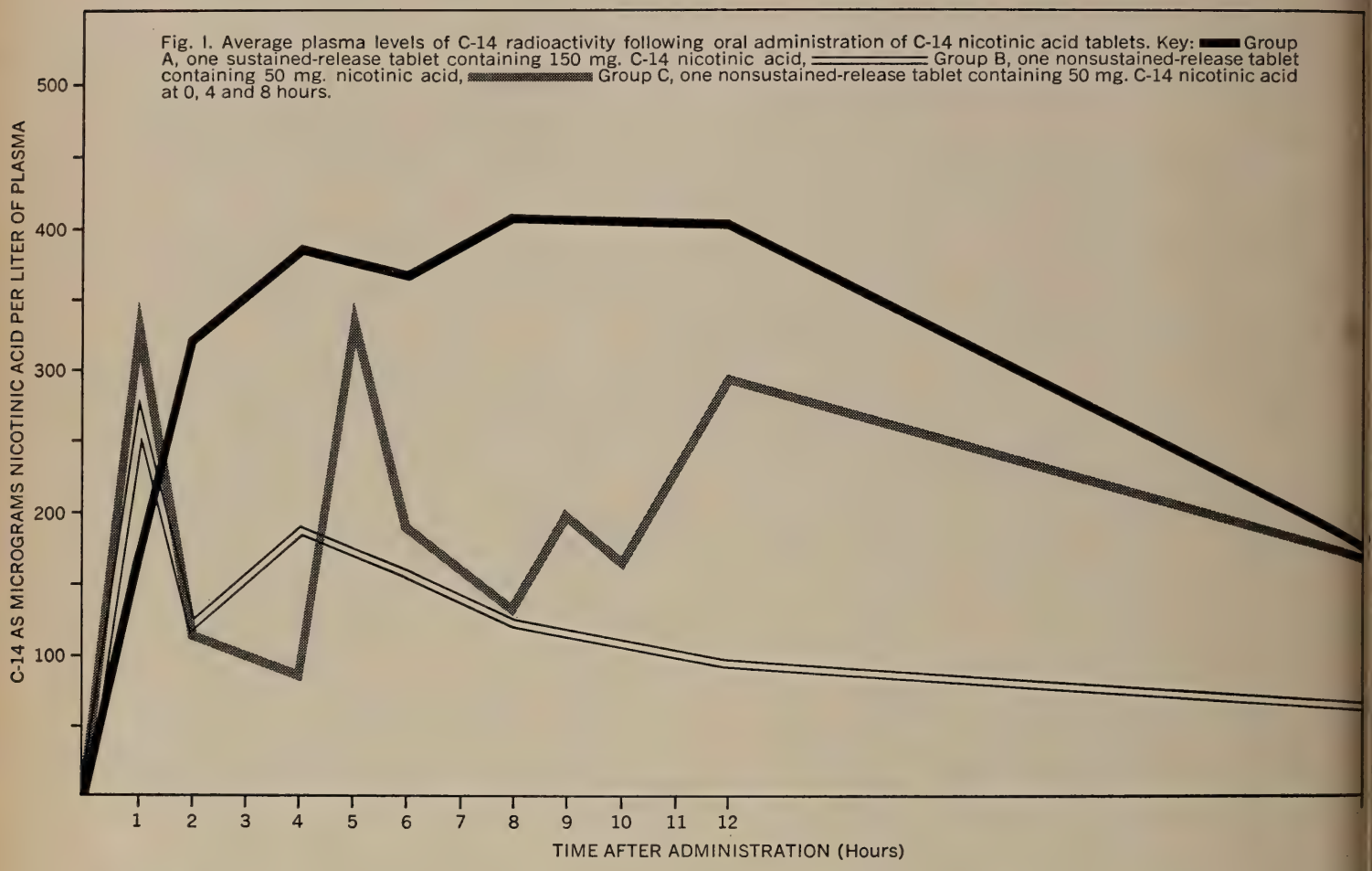
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plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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Norinyl® tablets

(norethindrone 2 mg. ē mestranol 0.1 mg.)

for multiple contraceptive action

AMA Issues Comprehensive Report on Distribution of Physicians

"Distribution of Physicians, Hospitals, and Hospital Beds in the United States" is the title of a 136-page booklet recently released by the American Medical Association.

A brief introduction of the methods used and an explanation of some of the data presented precedes statistical tables, giving information by cities, counties, etc., throughout the country.

Data on Ohio shows a total of 13,293 physicians, of which 8,894 are in private practice. Of the number in private practice, 3,343 are in general practice, 869 in general surgery, 1,146 in internal medicine, 624 in obstetrics and gynecology, 440 in pediatrics, and 243 in psychiatry.

The report indicates 192 hospitals in Ohio with 35,948 beds. The resident population of the state is 10,471,200; the per capita income, $2,235 and the income per household, $7,628.

The report makes this observation: "The fact that a physician is not in private practice *does not* preclude his seeing patients. Indeed, many physicians in this category, do see and render care to patients continuously. Interns, residents and other full-time staff in hospital service, as well as physicians employed as full-time medical school faculty and those listed under preventive medicine, do see patients in the every day activities connected with their salaried positions. A number of these physicians may even have small part-time practices of their own."

The booklet may be purchased from the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610 at $1.00 for persons in the U. S.

Cincinnati Heart Studies Are Backed By Seven Year Grant Extension

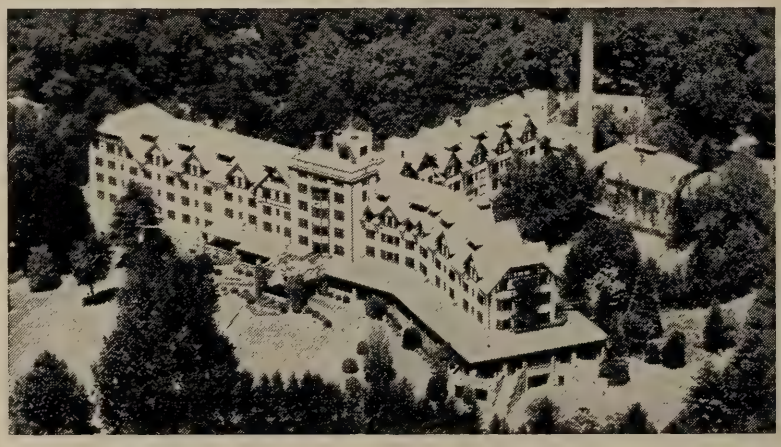
The University of Cincinnati Medical Center has received approval of a $1,304,000 grant from the National Institutes of Health extending the Cardiac Research Center's studies for an additional seven years.

The center will receive from the National Heart Institute $186,287 each year from October 1, 1968 to October 1, 1974 for costs of its extensive research program.

This is the second seven-year grant the Cincinnati center has received from NIH. The project was started in 1961 and is now in its sixth year. The initial phase has been backed by $1,204,500 in NIH funds. Dr. Noble O. Fowler, professor of medicine, is principal investigator.

Dr. Henry G. Cramblett, chairman of the Department of Medical Microbiology in the Ohio State University College of Medicine, has received an unrestricted grant of $3,000 for medical research from Wyeth Laboratories, Philadelphia.

Appalachian Hall • ESTABLISHED 1916 Asheville, North Carolina



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients

Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town in the beautiful Smoky Mountain Range, an ideal location for rehabilitation.

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For rates and further information write APPALACHIAN HALL, Asheville, N. C.

Soyalac SOLVES THE PROBLEM

...and BABY APPROVES!

Baby has a thing or two to say about a hypo-allergenic, milk-free diet!

Soyalac is the good-tasting, fibre-free formula that infants readily accept. The exclusive Soyalac process results in a consistency much like milk, with a light, creamy color—and nut-like flavor but without a trace of sediment.

Soyalac satisfies the infant. Strikingly similar to mother's milk, it provides protein of high biologic value and balanced nutrients. Clinical data furnish evidence of Soyalac's excellence in promoting normal growth and development.





Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

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RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U.S.A.

In Our Opinion

Comments on Current Economic, Social And Professional Problems

BRAND VS. GENERIC NAMES; A PHYSICIAN'S COMMENTS

Identification of the source of a product has always been an advantage for the user and, with a product of good quality, a matter of pride for the maker.

Nothing was ever devised by mankind, to provide the inspiration for and the guarantee of excellence, to rival the custom of a superior workman to sign his work or otherwise identify himself with his creation.

Artisans like Stradivarius have made their names so famous as to make unnecessary the mention of their product. Someone in Washington should tell Heifitz how much money he could save with a "generic" violin.

It is self-evident that rules for quality apply to drugs as well as to all other products; and in the case of drugs where casual observation, even by an expert, is of little aid in determining quality, the name, honor and reputation of the maker is of supreme importance.

If large sums of money were to be saved by prescribing generic drugs of unidentified origin, the present suggestions for the universal use of generic drugs might have some rational basis. However, a review of several thousand prescriptions written for a welfare service shows that, if all the drugs were dispensed as generic items, only five per cent of the cost would have been saved from the cost of brand name products.

The level of manufacturers' prices for all prescription drugs has been falling for the past several years while the cost of living index has been rising. During this same length of time, the price of patented drugs has fallen faster than the price of non-patented drugs.

Brand name pharmaceuticals are not expensive; their cost covers the one ingredient without price — the guarantee of highest quality enjoined by the pride of workmanship.

In the life-saving business, a cheap drug might be the most expensive thing in the world. — Editorial comments in the August issue of *The Journal of the Indiana State Medical Association* by Frank B. Ramsey, Editor.

GOVERNMENT POLICIES ARE INCONSISTENT, CONTRADICTORY

When President Johnson recently ordered a study of rising medical costs, he was condoning at the same time increases in airline mechanics' wages, steel prices and interest rates along with other inflationary measures.

Since the government has decided to insure the elder citizen against medical and surgical hazards, irrespective of his financial status, and funds for health care of children up to 21 on a semi-needy basis, why should the doctor not charge the government his standard, usual, customary, and reasonable fee for service.

Doctors are the only vendors of welfare who have for years given their services either free or at a discount rate. Doctors rarely retire at age 65 and are paying the full social security tax for benefits they never will receive. Due to the shortage of physicians, there is more need than ever for them to stay on the job.

If quality medical care is what the government wants the elderly and the needy to receive on the Health, Education, and Welfare Medicare and medical assistance programs, then it hardly makes sense for government to refuse to pay what other patients pay. When government suggests the medical profession is profiteering, because it is unwilling to subsidize federal spending for health care, then government is blaming the doctor instead of those who voted for the health care laws, which have never worked in other countries and always have destroyed the quality of medical care as well as tremendously increased the cost to everyone through taxes.

Regardless of the criticisms that fall our lot, it is the physician's responsibility to prescribe those medications which will most effectively aid in the recovery of the patient. This responsibility cannot be delegated to any politician, government official, or pharmacist. If he can minimize the injury to the patient's pocketbook, this is desirable. However, it is false economy to prescribe a drug under its generic name if there is reasonable doubt about the clinical acceptability and effectiveness of the brand that will then be dispensed by the pharmacist. — William M. Straight, M. D., in *Bulletin* of Dade County (Fla.) Medical Association.

Vital Statistics in Ohio ...

Ohio Department of Health Issues Annual Report On Number of Births, Deaths, etc., in the State

THE Ohio Department of Health recently released the 1965 Annual Report on Vital Statistics, an 86 page booklet with a narrative description as well as statistical data. Information was compiled under direction of Dr. Emmett W. Arnold, director of the Department, and William Veigel, chief of the Vital Statistics Division. Following are excerpts from the report.

Population

In 1965, the July 1 estimate of population for Ohio was 10,564,144, an increase of 138,969 or 1.3 per cent over the 10,425,175 estimate for July 1 1964. An excess of births over deaths (net natural increase) accounted for 103,462 or over 74 per cent of this increase.

The 1965 mid-year population estimates for the State, counties and cities were used to compute rates based on population shown in this report.

Live Births

There were 194,927 live children born to mothers residing in Ohio during 1965, 14,553 fewer than were born in 1964. This is the eighth consecutive year that the actual number of births has been less than the preceding year's total. The live birth rate was 18.5 per 1,000 population in 1965, nearly 8 per cent less than the 20.1 rate in 1964 and the lowest in the State since the rate of 17.7 in 1941.

During 1965, there were 99,497 male and 95,430 female resident births in Ohio. The sex ratio of 1,043 males for every 1,000 females was lower than the sex ratio of 1,063 males to 1,000 females in 1964.

White births totaled 173,914 in 1965. This is a decrease of 13,182 from the 187,096 white births in 1964. Nonwhite births decreased 1,371 in number from the previous year. The number of nonwhite births for 1964 and 1965 were 22,384 and 21,013 respectively. The white birth rate decreased from 19.6 in 1964 to 17.9 per 1,000 white population in 1965. The nonwhite rates showed a decrease from 26.2 in 1964 to 24.2 per 1,000 nonwhite population in 1965. The nonwhite birth rate is over 35 per cent higher than the white rate for the year 1965.

For the calendar year 1965, the natural increase in the population (excess of births over deaths) was 96,635 giving a total resident birth rate which exceeded the death rate by 9.2 per 1,000 population. For the white population, the rate of increase was 8.7 per 1,000 and for the nonwhite population, 14.4 per 1,000.

In 1965, there were 190,905 single and 4,022 plural resident live births in Ohio; 3,996 were born in twin deliveries and 26 were born in higher order deliveries. The plurality rate of 20.6 per 1,000 live births was similar to the rate of 20.5 in 1964.

Illegitimate live births increased from 12,775 in 1964 to 13,282 in 1965. The illegitimacy ratio of 68.1 per 1,000 live births represents a 12 per cent increase over the ratio of 61.0 in 1964.

Approximately 28 per cent of the total number of live births to resident mothers of Ohio were first born children, and over 22 per cent were second births.

Women between the ages of 20-29 years were responsible for over 61 per cent of the total number of live births. Mothers in the age group 20-24 years represented 36 per cent of this figure, while 25 per cent is accounted for by those in the age group 25-29. There were 286 births to mothers under 15 years of age and 253 births to mothers 45 years of age and over.

Premature Births

Premature births, those with a birth weight of 2,500 grams or less, totaled 15,451 or 7.9 per cent of all Ohio resident live births in 1965. The premature birth rate of 79.2 per 1,000 live births, showed no appreciable difference from the 1964 premature rate of 78.8.

Fetal Deaths (Stillbirths)

In 1965, the number of resident fetal deaths reported was 2,697 — 256 less than were reported in Ohio during the year 1964. The fetal death rate per 1,000 live births was 13.8.

Infant Deaths

Ohio's resident infant deaths decreased from 4,614 in 1964 to 4,346 in 1965. The infant death rate per 1,000 live births showed an increase from 22.0 in 1964 to 22.3 in 1965. The nonwhite infant death rate of 37.2 per 1,000 live births was 81.5 per cent higher than the white death rate of 20.5 per 1,000 live births.

Deaths peculiar to early infancy accounted for 2,708 or 62.3 per cent of the 4,346 deaths under one year of age. Congenital malformations were the cause of 728 infant deaths. There were 514 deaths due to diseases of the respiratory system, 125 due to



The synthesis of cortisone was accomplished by Merck Sharp & Dohme in 1948—the famous "Compound E" used by Dr. Philip Hench in his historic experiment at the Mayo Clinic.

But proud as we are of our role in the development of cortisone and subsequent corticosteroids, we have continued to seek a greater understanding of arthritic disorders and new drugs for their treatment.

One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.

MSD **MERCK SHARP & DOHME** | **where today's theory is tomorrow's therapy**
Division of Merck & Co., INC., West Point, Pa.

INDOCIN®
INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.
Contraindications: Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.
Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
Before prescribing or administering, read product circular with package or available on request.

accidents, and 81 due to diseases of the digestive system.

Neonatal Deaths

Neonatal deaths (those occurring within the first 27 days) accounted for 3,217 or 74.0 per cent of all infant deaths for the year 1965 in Ohio. In 1964, 3,560 or 77.2 per cent of the infant deaths were reported as neonatal deaths.

Maternal Deaths

In Ohio, the 43 maternal deaths in 1965 resulted in a resident maternal death rate of 2.2 per 10,000 live births, lower than the 58 deaths with the rate of 2.8 per 10,000 live births in 1964.

Deaths — All Causes

There were 98,292 deaths among residents of Ohio in 1965, an increase of 1,737 over the 1964 total of 96,555. The crude death rate of 9.3 per 1,000 population was the same for 1964 and 1965.

Leading Causes of Death

The leading cause of death in 1965 for all ages was diseases of the heart with 39,500 deaths, or 40 per cent of all Ohio resident deaths. Malignant neoplasms was the second leading cause with 16,336 deaths, and a death rate of 154.64 per 100,000 population. Vascular lesions affecting the central nervous system with 11,156 deaths was the third and accidents with 5,223 deaths the fourth leading cause of death.

Accidents continued to be the leading cause of death for both males and females in each group between 1-24 years and appears among the five leading causes of death for both sexes in the 25-44 and 45-64 years age groups.

Heart disease replaced accidents as the leading cause of death among males in each age group over 35 years. However, malignant neoplasms became the leading cause of death among women in the 25-44 and 45-65 years age groups, while heart disease ranked first among the females in the age group 65 years and over.

Marriages and Divorces

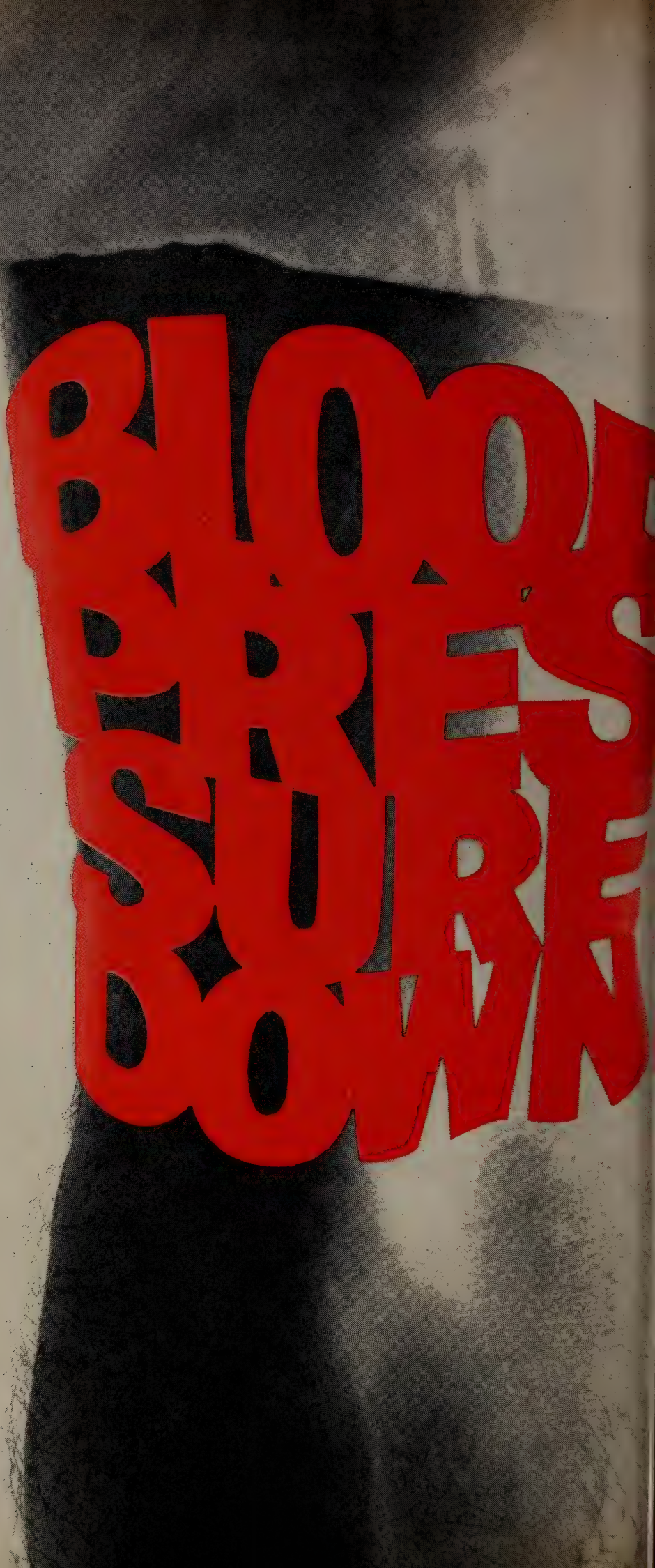
The year 1965 showed an increase of 4,003 marriages over the previous year. There were 78,982 marriages performed in Ohio in 1965 representing a marriage rate of 7.5 per 1,000 population.

Study of Adolescents

Dr. Philip A. Marks, professor in the Department of Psychiatry, Ohio State University College of Medicine, has received a $27,327 grant from the National Institutes of Health to develop personality descriptions of emotionally disturbed adolescents.

According to Dr. Marks, the funds will be used to provide an extensive set of personality descriptions. Included in the study will be over 2300 males and females in a nationally representative sample drawn from private, clinic, and hospitalized patients.

When thiazide or reserpine alone won't keep





Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

The Historian's Notebook

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M. D., M. P. H.*

PART IV

(Continued from September Issue)

THE triennial summary published in 1918 by Cincinnati Health Commissioner, Dr. W. H. Peters (1916-1934), continued the Child Hygiene report as follows:

The health promotion of school children is a function of the Health Department cooperating with the Board of Education . . . Open-air rooms for anemic children are located in the Sands, Guilford, Douglas and Rothenberg Schools. Tuberculous children are cared for at the Cincinnati Tuberculosis Sanatorium. In the operation of school dental clinics, the splendid cooperation and assistance of the Oral Hygiene Committee of the Cincinnati Dental Society is gratefully acknowledged. In Cincinnati the work undertaken for the first time in 1914 by the Little Mothers' League has as a primary objective the promotion of "personal hygiene" and is designed "to conserve the health and lives of infants. School houses are used as meeting places. Children arriving at the lawful age for employment are examined by district physicians to determine fitness for employment . . ."

Code Enforcement

On enforcement of the codes, Dr. Peters notes that the use of the courts for enforcing department orders is an absolute necessity and is unquestionably one of the best and quickest methods of procedure when the property owner is within the jurisdiction of the court. During the past three years, 441 prosecutions were completed. The Department also has long believed that in order to help solve the housing problem it is necessary to pay more attention to the tenants. In the past few years the department inspectors have been instructed to hold tenants responsible, wherever possible, for minor nuisances. During 1916 the Housing Committee of the Woman's City Club published a primer for the education of tenants . . . Ten thousand placards, notifying tenants of their responsibility for keeping the premises clean, were also posted. The placard contained the following notice and warning in English, German, Italian, Yiddish, Hungarian and Roumanian:

NOTICE

This house must be kept clean and free from dirt, filth, garbage or other matter. The yards, courts, passages, areas or alleys, and all rooms, stairs, floors, windows, walls, ceilings, halls, cellars, and water closets must be kept in a clean condition at all times.

BY ORDER OF
THE BOARD OF HEALTH

Warning: Every person who shall violate or assist in the violation of this notice shall be subject to penalty of law . . .

Health Education

This was also a time for health education in a large way and examples of posters are given in their annual reports — posters on the dangers of coughing and sneezing, in the spread of "colds, influenza, pneumonia and tuberculosis," posters on the dangers of the common house fly. "Thousands of people die every year as the result of diseases transmitted by flies" the message reads, and further: "Destroy their breeding places, screen the windows, KILL 'EM . . ."

An interesting side issue is noted:

Owing to the great abuse of the milk bottle, the Milk Exchange of the Cincinnati Chamber of Commerce employs an inspector on full time whose duty it is to see that bottles are not hoarded or destroyed and to prevent one dealer from using another's bottles. . .

Meat Inspection

On meat inspection it is noted that "the local abbatoirs, under municipal inspection, have made steady progress along the line of sanitation and improved methods . . ."

Rabies

On rabies, Dr. Peters writes,

It is exceedingly unfortunate that the public is not properly informed. Do not kill the dog doing the damage. Nothing is to be gained by destroying the animal. A negative laboratory report gives a false sense of security. In 1916, 73 cases of suspect rabies were investigated. Of these 22 were killed and the brain examined. Nine gave positive reactions for the presence of Negri bodies . . .

1919 - 1930

Dr. Peters' reports for the year 1919 and for several years thereafter, were issued in the form of monthly bulletins, at first entitled CINCINNATI SANITARY BULLETIN and later changed to CINCINNATI'S HEALTH.

This has the effect of making them more difficult to research, as many of the articles take the form of

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted March 16, 1966.

Galileo needed the leaning tower of Pisa!

For over 1500 years the world believed that a heavy stone fell faster than a light one because Aristotle said so. Since this made sense, Galileo thought so too. But, being a curious fellow, he wanted to prove it; he climbed 297 steps to the top of the Leaning Tower of Pisa and dropped 2 stones, a heavy one and a light one, over the edge. Much to his surprise, and the surprise of everyone else, both stones struck the ground at the same time. Proof — a 1500 year old dogma destroyed in seconds by a simple experiment. It seemed that Aristotle had been talking through his ancient hat.

And like Galileo, you probably believe a statement you have heard over and over again. How many times have you been bombarded with the fact that brand name products are better than generic name products? Often enough that no doubt you believe it to be true. But now let's do the simple test which, like Galileo's experiment, will take but seconds.

Send for sample of West-ward's Prednisone Tablets 5 mg., sold under the generic name, by returning coupon below, and upon receipt do this simple test and see for yourself: Examine tablet carefully, break it between your fingers and listen to the snap. A good snap indicates a hard, well compressed tablet. Then take a tablet, drop it into a glass with about 20 ml. water and swirl gently. Note that it disintegrates in a matter of seconds into **finely divided particles.** Here is what this means:

A. Fast distintegration means more rapid absorption
B. **Fine particles** mean more complete absorption
C. Result: Optimum physiological availability[1,2,3]

To determine that West-ward's Prednisone Tablets 5 mg. are the very best you need not climb that tower; all you need do is send for sample bottle of 12 tablets and do the test.

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health educatory admonitions to the public. The bulletin for January 10, 1919, starts off with the brave words: "Sacrifice and cooperation have been the key words in the Health Department during the past year. Twenty-four employees, representing all divisions, were inducted in the military service and most of them are 'over there.'"

As to progress, in CINCINNATI'S HEALTH, Dr. Peters adds up these as rungs in the ladder:

1. The Chief Food Inspector has rendered a distinct service as Food Administrator for Hamilton County.
2. In the Division of Medical Relief and Inspection the doctors and nurses have been carrying on a fine piece of constructive work, examining children of pre-school age in conjunction with the Child Welfare Committee, and the Women's Committee of the Council of National Defense.
3. Cooperating with the United States Public Health Service and the Ohio State Department of Health, a Bureau of Venereal Diseases has been established with offices in the Blymyer Building.
4. The establishment of the Oyler Health Center was a distinct innovation.
5. Universal pasteurization of market milk undoubtedly has saved many lives.
6. The Sanitary Division has done effective work in eliminating or correcting thousands of unsanitary conditions. Its campaign of education in the tenement districts met with hearty approval of the landlords and was appreciated by self-respecting tenants . . .

Public Comfort Stations

On public comfort stations he writes:

Municipalities have begun to recognize the need for first class comfort stations located in the congested districts. Besides those located in the public parks, three have been built in business sections; Fifth and Walnut Streets, McMillan Street near Gilbert, and Spring Grove near Hamilton Avenue. (But these latter are now closed down alledgedly because of "ill use" by "certain publics" and cost of supervision and maintenance.)

The "Flu" and After

Bemoaning the ravages of the pandemic of influenza, Dr. Peters also notes:

Now that soldiers are returning from overseas, health officials and local physicians will have to exercise the greatest vigilence in order that exotic epidemic disease may not be carried into this country and spread with disastrous results . . .

With war's final end, many war buildings, war jobs, and war institutions will go to the scrap heap. But every item in the program of venereal disease control is as necessary to successful peace as in successful war . . .

The Ubiquitous Cuspidor

On cuspidors, Dr. Peters writes:

Human sputum is dangerous. The habit of certain workmen of expectorating in the corners, on the stairs, in the toilet rooms, and on the floor of factories is dangerous to the health of everyone in the vicinity. The ordinary cuspidor is generally very unsightly and is exceedingly repulsive to clean. The modern flush rim water-supplied cuspidor, with waste pipe connected to the sewer, offers a solution for quick and sanitary removal of this possibly infectious material. Their installation is recommended . . .

Cost of Health

And once more like his predecessors had stated a thousand times, he writes:

The yearly toll of nearly a thousand victims of tuberculosis does not create much concern, and yet it is the one disease that is robbing the city of its fair name. The per capita cost for fire protection in 1919 will be $2.24; for police protection, $2.38; for health protection, 28¢. If we could have a fixed rate for public health purposes — and surely a per capita of 50¢ would not be too much — we could enlarge our forces so as to provide adequate dispensary service for tuberculous individuals and suspects . . .

Reporting of Tuberculosis

And on the reporting of tuberculosis, he notes:

It is generally conceded that for every death from tuberculosis there are five active cases, which means that approximately 3,500 cases have not been reported (1,280 were). The situation is a serious one. Many physicians are not reporting their known cases; others are slow in establishing a diagnosis. Not all diagnostic means are employed to clear up doubtful cases . . .

Negro Health

In discussing a program for the future he stated that he would like to stress "particularly the need for increasing the medical and nursing service so that we can furnish prenatal and postnatal service and provide adequate dispensary service for tuberculosis, and give a little more attention to the Negro health problem . . ."

On a Variety of Things

On first aid in cases of apparent drowning he writes: "Barrel rolling is out of date just as punching a drowning person in the face is unnecessary on the part of a lifeguard. The Schafer face-downward method of resuscitation is best . . ."

On "cold storage" he notes that this has developed

with amazing rapidity into a gigantic industry . . . that we have been confronted with some perplexing problems in the control of our food supply. There is a woeful lack of federal, state, and municipal legislation for the control of stored foods. Let us go to the matter with catholic mindedness. Cold storage is a great boon to civilized life, which should not be lost sight of in formulating regulations for its control . . .

On the value of the Schick Test and Toxin-Antitoxin immunization in the control of diphtheria, he writes:

The efficiency of anti-diphtheritic serum in protecting persons exposed to diphtheria is generally recognized, but for various reasons serum treatment is not always desirable. The duration of immunity conferred by the prohylactic injection of antitoxin being short and there is the possibility of sensitization. Immunization with toxin-antitoxin mixture is of no value as an immediate protection as it requires several weeks to establish immunity, but for general prophylaxis in institutions and families it is of great service . . . Let us see if we cannot develop a 100 per cent immunity among all children under institutional care. The procedure is simple and inexpensive.

The dosage of diphtheria antitoxin given as immediate prophylaxis or for treatment is as follows: A single dose of the proper amount as indicated on the schedule . . . 500 units for children under 12 and 1,000 units for others will suffice, etc.

(Continued in November Issue)

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The Many Faces of Depression*

IAN GREGORY, M. D.

IT HAS BEEN remarked that insanity is like the rain, falling alike upon the evil and the good. So also do the varied moods to which we are all subject. Joy and sorrow; fear and anger; each of these emotions normally arises in response to a particular kind of event or situation. Attaining a desired goal usually leads to happiness or joy. Danger or the anticipation of disaster result in fear. Loss results in grief and depression. Frustration leads to anger, and sometimes to impotent rage and depression.

Pathological depression, however, differs from normal grief in several ways. It may differ in quality or quantity, intensity or duration, and it may be disproportionate to any external loss or frustration. It has been remarked that one man's meat is another man's poison, and events that lead to joy in one household may lead to despair in another. But the nature of loss and frustration also changes during the course of an individual's lifetime, in accordance with changes in the objects of his love and the goals that motivate him. The latter in turn result in changing rationalizations and beliefs. As one example of a frequent change in conscious attitude and conviction, consider prevailing attitudes toward premarital chastity among young adult males, and among the same men later in life when they have become the fathers of teenage daughters.

Emotions and conscious attitudes also change within much shorter periods of time, as witnessed by the man who was asked, "What do you especially like about living in this neighborhood?" He replied, "It is nice and friendly. The folks are always coming to visit us and we visit them; there are lots of kids around." Then he was asked, "What are the things you don't like about it?" He thought for a moment and answered, "The same things, I guess."

In the short space available, I want to paint a few portraits that may help to give some idea of the range of individuals in whom depression is observed and the extent of its manifestations. Let us think first of a little child who has been admitted to the hospital, is surrounded by strangers, and is fearful of what is going to happen to him. In the absence of visits by members of his family, it may not be long before the child seems to wilt and curl up, sitting quietly and showing no interest in food or in what is going on around him. He may cry at first, but then the tears dry up and he just looks empty, with no variation in expression, clutching to a single toy that he has brought from home, which represents something familiar — some straw to prevent him from drowning in the sea of troubles around him. Such children may not only show regressive behavior, but also have a higher mortality than others who do not experience abandonment.

Next, let us take a look at the other extreme of life, at an old man who has been left alone after his wife has died. In earlier years he enjoyed working hard, but this has been taken from him by retire-

The Author

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*From a paper presented at the First Ohio Congress on Psychological Medicine, October 24, 1965.

ment and he feels he has been placed on the shelf. His children have grown apart from him over the years and he feels they no longer have any time or use for him. His former friends have moved or have other interests from which they seem to exclude him. His life is empty, devoid of satisfaction, and he can see no prospect of improvement. He sits quietly in his solitude and despair until one morning he shoots himself. His depression might have been foreseen and prevented, or it might have been alleviated by treatment after it had developed.

The majority of persons, however, who commit suicide as a consequence of depression have not previously received psychiatric treatment, although they have often told other persons of their suicidal intentions beforehand. Successful suicide remains about three times as frequent in men as in women, and about three times as frequent among persons over the age of 60 as in young adults — but it may occur at various ages and in all walks of life, if the individual feels sufficiently desperate.

Let us turn now to look at a middle aged woman, 53 years old. The woman grew up on a farm and learned to live in conformity with the demands and expectations of her family and society and religion. She attended church regularly and visited the neighbors, but most of her satisfactions were found at home with her family. She was a meticulous housekeeper and very attentive to the care of her husband and children. Three years previously, her husband had been admitted to hospital with tuberculosis, and had remained there ever since. Her sons had continued to work on the family farm but were now growing up and spending many of their evenings away from home. The woman herself no longer found satisfaction in the simple things she had previously enjoyed but became increasingly withdrawn and unnecessarily concerned over their financial affairs. Housework became a tremendous effort for her, but she was extremely conscientious.

On the morning that she was finally admitted to the hospital, she had gotten up at 5:00 A. M. as usual to cook breakfast for her sons. She was practically mute by this time, hadn't been eating, and had lost a lot of weight. Her lips were dried and parched, and she responded to questions very briefly or not at all. She looked the picture of dejection and periodically moaned, said that she had sinned and that God would punish her. This was before the days of modern antidepressive drugs, and she was considered inaccessible to psychotherapy. After a few electroshock treatments, however, there was a dramatic improvement in mood and activity level, and she could now be involved in individual and group psychotherapy. After a few weeks she returned home with renewed inner resources for adaptation, and continuing efforts were directed toward developing further sources of environmental support in the community.

Paradoxical Grief

The next and final illustrative case history concerns a woman, 20 years younger than the preceding one, whose overt reaction to the loss of her beloved husband presents a marked contrast. This woman had previously been the happy, jolly, relatively carefree wife of a farmer, with three young children. She was friendly and out-going, but not hypomanic, and had not experienced any severe emotional difficulties. One day her husband was driving her and four others to a plowing contest. She was sitting in the back seat of the car and felt car-sick, so her husband suggested that they change places. She took the wheel of the car and came to a railroad crossing where a train was approaching and the signal was flashing. She stopped, but the automobile behind her didn't and pushed her car onto the railroad tracks, where it stalled. She couldn't start it again, and at the last minute she called for everyone to jump out. Everyone was able to do so except her husband and a sister-in-law, and the husband was killed instantly.

For a very brief period she was numb with shock, but within a few days, she seemed to have completely gotten over the effects of her loss. There was a complete denial of grief and she became increasingly euphoric, stating that her husband was far happier with the angels than he would have been with her. She lost no time in buying a new car to replace the one that had been wrecked in the accident, and she drove this recklessly. She also purchased many other things beyond her means, including a truck, new tractor, implements for the tractor, a new coat and hat, a coat for her mother, an electric blanket, new beds for her own family and also for a neighbor's family. She asked for a private line on the telephone, which she was using at all hours of the night as well as the day.

When asked how she could pay for all her purchases, she said she was going to get $100,000 from the driver of the automobile that had pushed hers onto the railroad track. She became increasingly overactive, laughed frequently and told vulgar jokes, and eventually neighbors became so concerned about her inappropriate behavior that they arranged for her admission to hospital, at which time she threatened to sue both the neighbors and the hospital staff.

Here we are confronted with a paradoxical reaction bearing little superficial resemblance to grief. And yet the latter is evident in the subsequent turn of events. With phenothiazine therapy, the manic symptoms disappeared but were replaced by profound depression. After a few electroshock treatments and supportive psychotherapy, her mood stabilized and she returned home. She was able to look after her three young children, but no financial settlement concerning the accident was forthcoming without litigation, and it was necessary for her to sell the farm and equipment. One year after the

accident, she again became so depressed that one morning she drove her automobile out to the railroad crossing and waited for the train, which absolved her guilt by ending her life.

Internalized versus Externalized Aggression

It is generally recognized that depression may lead eventually to suicide, but it is frequently overlooked that the depressed individual may also endanger the lives of other persons around him. The mother of a young child who perceives her own life as hopeless and futile, may also perceive it as equally empty for the child that she would leave behind her if she committed suicide. She may therefore kill the child, and subsequently may either succeed or fail in her own attempt at suicide. Traditionally, society has been more lenient toward mothers committing infanticide than others who commit homicide as a result of mental disorder. There may be little difference in the symptoms of a depressed person who takes the life of another, however, whether the victim is an infant or a much older child of a psychotically depressed woman, or whether there are several victims such as the wife and children of a severely depressed man.

In any event, the danger to others does exist and may also represent the ultimate manifestation of previously repressed hostility or anger or rage. Depression is usually associated with anger. The depressed individual is frequently irritable and easily angered by those with whom he has the closest bonds of affection. Ambivalence, or love and hate for the same object (or person), is one of the most prominent dynamic features of depression. While the anger or impotent rage may be predominantly retroflexed (turned inward upon the self), at times it may be externalized or turned outward on others.

Not all suicidal attempts, however, should be regarded as resulting from retroflexed rage. In many instances, they may represent manipulative gestures that are consciously or unconsciously intended to provoke guilt and change the behavior of other persons responsible for the individual's loss or frustration. By and large, the greater the amount of consciously recognized and externally directed anger, and the briefer the duration of suicidal preoccupation prior to the attempt, the less likely it is to be a manifestation of psychotic depression, and the safer the therapist may be in treating the individual exclusively by psychotherapy and even without admission to hospital. In this connection, it should also be recognized that depression is not the prerogative of the conscientious individual with an enlarged super-ego or internal control system. The impulse-ridden individual with a sociopathic personality may also become severely depressed and may make genuine suicidal or homicidal attempts as well as manipulative gestures or threats. In evaluating the personality, one has to consider the tolerance of the individual for frustration as well as his super-ego controls.

Association with Somatic Manifestations

A number of manifestations of depression are somatic and may mimic various bodily illnesses. The depressed patient frequently consults a general physician with complaints of fatigue, exhaustion, loss of energy, constipation, loss of appetite and weight, impaired sexual function, dissatisfaction with various activities he has ordinarily enjoyed, or severe insomnia, which may involve not being able to go to sleep, or waking up in the middle of the night or waking up very early. In psychotic depression, the early morning may be the worst time of day, the time when thoughts of suicide are most prominent. There are frequent complaints of bodily dysfunction without obvious organic pathology. The depressed individual is often hypersensitive to bodily pain, just as the euphoric individual is "feeling no pain." I recall having seen a hypomanic woman walking around the ward singing gaily, happy as a clown, who happened to mention to an alert nurse that she had a little pain in her abdomen. Her temperature and white cell count were both markedly elevated, and she was found to have a perforated appendix. By contrast, the patient who is depressed is apt to be unduly sensitive to trivial bodily dysfunctions and may be preoccupied with the latter, whether or not he complains about them spontaneously.

It should not be overlooked, however, that the causal relationship may be reversed, and that depression may result from somatic disease in two general ways. The expression "seeing things through jaundiced eyes" implies that toxemia may lead to gloom, and there are many debilitating illnesses that may lead to exhaustion and despair. On the other hand, organic illness may lead to depression primarily for psychological reasons such as loss of health and anticipation of death, or frustrations imposed by limitations on enjoyed activities. Here again, there may be a paradoxical reaction, so that one may see a first attack of mania in an individual who has just lost his eyesight, has just developed tuberculosis, or has just been told that he is to die from cancer. The more frequent reaction under these circumstances, however, is one of grief and depression.

Dynamics and Causation

We come now to the question of what legitimate generalizations may be made about the development of depression. We have looked briefly at the individual differences in manifestations and they are enormous. Depression may occur in many forms and at various ages and in different walks of life. During the last century, many were interested in the descriptive similarities and in systematizing their observations. French physicians reported having observed alternating attacks of depression and excitement in the same individual, and Falret described this occurrence as "la folie circulaire." A few years before the end of the nineteenth century, Kraepelin was engaged

in classifying syndromes according to their apparent similarity and made a distinction between manic depressive psychosis and involutional melancholia. Additional diagnostic categories still in current usage include neurotic and psychotic depressive reactions, although the latter would appear to have no greater intrinsic justification than establishing "psychotic manic reaction" as a separate entity. Attacks of either mania or depression may follow recognizable exogenous stress or may appear to develop spontaneously (endogenously) without obvious precipitating factors.

The precipitating factors that lead to affective disorders may be predominantly biological, psychological, or socio-cultural. In a high proportion of cases, the depression develops in a psychological context involving loss (of a loved object, of health, wealth, self-esteem, etc.) or of persistent frustration. In analyzing the nature of frustration, three general forms may be recognized. External frustrations may obstruct the achievement of one's goals, and learning a tolerance for reasonable external frustrations is one of the tasks that confronts the child during the normal course of development. Internal frustrations involve an inability to obtain one's goals because of personal inadequacies, and these frequently confront the adolescent or young adult. The third common source of frustration is conflict, which may involve approach-approach (two mutually exclusive desirable goals), avoidance-avoidance (of two undesirable consequences), or approach-avoidance conflict (involving a desirable goal which cannot be obtained without undesirable consequences). The latter may be the most difficult to solve, and the one that we most often encounter clinically.

Predisposition to affective disorder is generally thought of in terms of personality development, which may also have biological, psychological, and socio-cultural determinants. The emphasis in recent years has been on the childhood learning of maladaptive patterns of behavior. It has been noted that depression is commonly associated with ambivalence, and with a harsh dominant hypercritical super-ego or internal control system. What kind of childhood experiences are likely to lead to this situation? What kinds of parental behavior are likely to result in the development of ambivalent relationships with others or lead to overwhelming conflict, frustration, and defeat?

Retrospective information suggests that there has frequently been prolonged exposure to excessive criticism and demands that can never be satisfied; technics of discipline that involve provoking guilt by shaming, rather than by direct punishment; threats to the individual's integrity and self-esteem, rather than criticism or punishment directed toward the action itself. Often it appears that there have been long years — not isolated traumatic events in childhood — but long years of parental over-control, criticism, demands, degradation, shaming, and indirect technics of punishment. There may have been placed on the individual high expectations for achievements beyond his capacities, with minimal rewards for such attainments as he could make.

The search for predisposing traumatic events or situations in childhood raises the question of whether childhood loss can sensitize the individual to depression in adult life. Loss at all ages may precipitate grief and depression, and it has been thought that the loss of a parent during childhood (by death or divorce) may sensitize that individual so that subsequent situations of loss and frustration will more readily lead to the appearance of clinical depression in adult life. There have been many studies in this area and a number of positive findings have been reported, but the statistical evidence is still uncertain. My own findings suggest that loss of the parent of the same sex during childhood is followed by an increased frequency of delinquency but not necessarily by an increased vulnerability to depression or other forms of psychopathology.

Treatment

After looking briefly at the many faces of depression and trying to make some valid generalizations concerning dynamics and causation, let me close by mentioning a few of the major approaches to therapy. The latter may be viewed in the same light as the treatment of other forms of psychopathology, and hence as either reparative or reconstructive. Symptomatic (reparative) measures are directed toward relieving the depression itself, toward enabling the individual and the family to overcome the immediate problems raised by the depression. But there is also the question of preventing a recurrence in the future, improving the life-long adaptation by means of personality reconstruction, and trying to enable the individual to lead a more satisfying and rewarding life in the future.

Symptomatic measures include supportive psychotherapy, drug therapy, social or milieu therapy, environmental manipulation, and electroshock treatment if the latter should become necessary. Reconstructive therapy designed to strengthen the adaptive resources of the individual requires a prolonged period of time and involves the analysis of unconscious motivation. There are some special problems in undertaking such intensive psychotherapy with patients known to be prone to severe depression. Increased insight or awareness of hitherto unconscious motivation, or of the external reality situation, may of themselves mobilize increased depression. The procedure may be likened in part to holding a mirror up to the individual so that he may see his own motives more clearly. It may also be likened in part to providing him with a pair of glasses that will enable him to perceive external reality more accurately. In either event, the patient may need his blindness and may be disquieted by his improved vision. It may be primarily depressing rather than anxiety-

provoking to the patient so that interpretation and the acquisition of insight must be accomplished cautiously.

Apart from the fact that intensive psychotherapy may be unduly painful or prolonged, there are many patients with depression whose age or reality situation make them unsuitable candidates for this form of therapy. Even if it is contemplated at a later date, when a patient is currently severely depressed, he may be more appropriately treated by symptomatic measures, including supportive psychotherapy designed to boost self-esteem and utilize his adaptive resources.

Many drugs have been tried in the treatment of depression but few have been proven effective over a period of time. Sedatives and tranquilizers have some application in reducing associated anxiety, insomnia, sleep deprivation, and possible fragmentation of thinking. Stimulants such as the amphetamines have often done more harm than good, since they are likely to increase anxiety, insomnia, and any associated thought disorder. Even if the stimulant produces a temporary elevation of mood, there may be a rapid rebound depression of even greater intensity, during which the individual is sufficiently mobilized to attempt suicide. During the past few years however, there has been a great increase in the availability of psychotropic drugs, and the more recent antidepressive medications such as Parnate®, Tofranil®, and Elavil®, appear to be much more beneficial in the symptomatic management of depression than the earlier stimulants, sedatives, or tranquilizers.

It has been questioned whether electroshock should be used in the treatment of depression or any other psychiatric disorder. The evidence in its favor, however, is stronger in the case of psychotic depression than of any other psychiatric syndrome. While medication and other measures frequently render it unnecessary, and may in future render it altogether obsolete, at the present time electroshock may still produce a remission of psychotic depression more rapidly and more reliably than any other form of treatment currently available.

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2. Rosen E., and Gregory, I.: *Abnormal Psychology,* Philadelphia: W. B. Saunders Co., 1965, Chap. 14.

A VIEW OF THE FUTURE — I am going to make an optimistic prediction, based on my conviction that the medical practitioner must come to play an increasingly important role in the prevention and treatment of mental disorders. I will predict that in the years to come, the medical student will be taught psychiatry in its appropriate context — the medical ward and the medical clinic — and not in the psychiatric hospital and the separate psychiatric clinic. I will predict that the newer kind of medical interview behavior which will result will be further reenforced during internship, residency training and postgraduate medical education. Thus, new medical interviewing techniques will permit the physician to deal with the whole patient rather than with isolated organ systems.

The role of the psychiatric consultant, as that of other consultants, will be to advise the family practitioner when asked to do so, and to treat only patients with complicated psychiatric disorders that are too time-consuming for the circumstances of family medical practice.

Family physicians will play a vital role in the function of community mental health centers, both in knowing how and when to make referrals to such centers and in contributing time to the actual functioning of such centers. With the necessary knowledge of how to detect psychic disease and how to treat emotional disorders effectively, the family physician will prevent many of the instances of progression to chronic psychiatric illness with which we are now plagued. — Allen J. Enelow, M. D., Department of Psychiatry, University of Southern California School of Medicine, Los Angeles: "Prevention of Mental Disorder. The Role of the General Practitioner," *California Medicine,* 104:16-21, January, 1966.

Hemocholecyst

Report of a Case Associated with Anticoagulation Therapy

JANE BRAWNER, M.D., HARGOVIND TRIVEDI, M.D.,
and LEE R. SATALINE, M.D.

MASSIVE hemorrhage into the gallbladder (hemocholecyst, hemobilia, hematobilia, gallbladder apoplexy) is an uncommon condition usually associated with trauma,[1] neoplasms,[2,3] inflammation,[4] cholelithiasis,[5] or aneurysmal vessels[6,7] of the liver or gallbladder. Four cases of "spontaneous" hemobilia have been reported[8,9] for which some authors[8] postulated that hypertension with arteriosclerosis may have been responsible. Recently we observed a case of hemocholecyst in a cardiac patient taking bishydroxycoumarin (Dicumarol), who later developed acute cholecystitis while under treatment for acute myocardial infarction. We were unable to find a similar case in the literature.

Case Report

A 73 year old man was admitted to Lakewood Hospital with epigastric pain accompanied by nausea and vomiting. These symptoms, which began suddenly two days before admission, gradually increased in severity and were unrelated to food ingestion or bowel movement. There was no radiation of the pain. The patient had no previous gastrointestinal symptoms and he denied food intolerances. There was no history of trauma or liver disease.

Seven years before this admission, he was started on treatment with digitoxin and diuretics when he developed leg edema. Documented myocardial infarctions occurred five, three, and one year before admission. After his first infarction, he was placed on long term Dicumarol therapy, and his prothrombin activity was maintained between 20 and 40 per cent on doses of 50 to 75 mg. daily. There had been no episodes of abnormal bleeding, and a prothrombin determination two weeks before admission was 18 per cent (Quick, one-stage method). One day before admission, after the onset of pain, he voluntarily discontinued the Dicumarol.

On admission, physical examination revealed a well-nourished afebrile man in no acute distress. His blood pressure was 180/100 mm. Hg, pulse rate 120, and respiratory rate 24 per minute. The ocular fundi showed grade 2 arteriosclerotic changes. The lung fields were clear. The heart was enlarged, and the apical impulse was felt in the sixth left interspace at the anterior axillary line. A grade 2/6 soft systolic murmur was heard over the entire precordium. The rhythm was regular. The abdomen was soft, and an ill-defined small, firm, tender mass was thought to be present just below the costal margin about 10 cm. to the right of the midline. Rectal examination revealed prostatic enlargement, and the stool gave a positive reaction for occult blood.

The admission hematocrit was 42 per cent, the white blood cell count 23,400 with 90 per cent neutrophils, 6 per cent lymphocytes, and 4 per cent monocytes. Urine analysis was unremarkable except for six red blood cells per high power field. Prothrombin activity was 58 per cent (36 hours after his last dose of Dicumarol). The serum glutamic oxalacetic transaminase was 17 units and lactic dehydrogenase 660 units. On the following day, these enzyme levels were 78 units and 920 units respectively.

The chest x-ray showed moderate cardiac enlargement and an abdominal film reportedly showed signs of ileus but no abnormal masses. (In retrospect, the radiology staff believes an enlarged gallbladder shadow may be discernible just below the liver.)

An electrocardiogram showed left ventricular hypertrophy and digitalis effect. ST segment elevation in lead V_{1-3}, with T wave inversion in leads I, AVL and V_{1-4} were believed indicative of a recent anteroseptal infarction superimposed on an old infarction pattern. An electrocardiogram the following day showed the development of a QS pattern in leads V_{1-3}.

Because of the electrocardiographic changes, the serum enzyme increases, and as no definitive lesion was demonstrated in the abdominal x-rays, the patient was treated for myocardial infarction. Anticoagulation therapy with Dicumarol was restarted, and the prothrombin activity was maintained between 20 and 40 per cent of control. The pain gradually subsided and disappeared completely by the sixth day.

During the next three weeks the patient's condition remained stable, and the serum enzymes and white blood cell count returned to normal levels.

On the 24th hospital day, the patient again began to complain of epigastric pain and nausea. The abdomen was tense and a 10 by 5 cm. mass was now definitely felt in the midclavicular line about 5 cm. below the costal margin. No areas of subcutaneous hemorrhage were noted. His temperature rose to 102°, and he vomited bile-stained material on several occasions. The white blood cell count increased to 15,900/cu. mm. with 75 per cent neutrophils, 21 per cent stab forms, and 4 per cent lymphocytes. The alkaline phosphatase was 15 units (normal 4-8), and the bromsulfalein retention 23 per cent in 45 minutes. The serum bilirubin, cholesterol, and amylase were normal. Repeat abdominal x-rays demonstrated ileus and a mass extend-

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From the Department of Medicine, Lakewood Hospital, Cleveland, Ohio. Submitted March 22, 1966.
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ing below the inferior margin of the liver, which was believed to be a distended gallbladder.

Tetracycline was begun and anticoagulation therapy discontinued. A supplemental injection of vitamin K_1 (20 mg.) was administered parenterally. Because his general condition continued to worsen and his temperature increased, surgical intervention was deemed mandatory on the 26th hospital day. At this time, his prothrombin activity was 68 per cent.

At operation, the peritoneal cavity was found to contain about 300 ml. of blood-tinged fluid. A 20 by 10 cm. mass was felt in the right upper quadrant, which, after clearing away the adhering omentum, was found to be an inflamed gallbladder. After opening the gallbladder, approximately 300 ml. of both fresh and clotted blood and 18 small faceted gallstones were removed. Because of the general condition of the patient, only a partial cholecystectomy was performed, and a No. 28 mushroom type catheter was inserted into the gallbladder remnant.

The postoperative course was stormy and complicated by bronchopneumonia and pyelonephritis. Cholangiography performed via the catheter on the 45th day demonstrated a possible calculus in the distal end of the common duct. However, another operation was deemed inadvisable at this time in view of the patient's poor general condition. The catheter became dislodged on the 50th hospital day and was removed. The patient was discharged 10 days later.

The surgical specimen consisted of a section of gallbladder wall about 10 cm. long and 250 cc. of clotted blood. The mucosal surface was hemorrhagic, ulcerated, and granular, and the serosal surface was hyperemic and granular. Microscopically, the gallbladder wall showed evidence of both acute and chronic cholecystitis. Several large areas of submucosal hemorrhage with rupture of the mucosa surface were seen (Fig. 1).

Discussion

We believe the hemorrhage into the gallbladder occurred prior to admission rather than during the third week of hospitalization. However, the lack of definitive clinical and radiological signs, coupled with the electrocardiographic and serum enzyme alterations, prompted us to relate the epigastric pain to a myocardial infarction with diaphragmatic irritation, a not uncommon occurrence. In retrospect, it is conceivable that the initial symptomatology was due to hemorrhage into the gallbladder, and the later abdominal complaints were secondary to the acute cholecystitis as the presence of a tender abdominal mass in the absence of fever on admission seems more consistent with hemorrhage than with cholecystitis.

Reports of anticoagulation therapy complicated by hemorrhage into the meninges,[10] intestine,[11] adrenal gland,[12] peritoneum[13,14] muscle,[15] pericardium[16] pituitary gland adenoma,[17] breast,[18] and central nervous system[19,20] have been published. To our knowledge there has been no previously reported case of hemorrhage into the gallbladder associated with anticoagulants.

Hemorrhage into tissues during anticoagulant administration has several outstanding manifestations[12]: (1) The demonstration of an overt hemorrhagic tendency is uncommon; (2) One rarely observes concurrent hemorrhage into the skin and subcutaneous tissues; (3) Hemorrhage has been associated with several types of anticoagulants including bishydroxycoumarin, warfarin, heparin, and phenindione; (4) There is no definite relationship with the duration of therapy or the dosage of anticoagulants given. While hemorrhage was often related to anticoagulant overdosage, in many instances the prothrombin activity



FIG. 1. *Photomicrograph of section from gallbladder wall showing extensive submucosal hemorrhage* (arrow). *Original magnification x 450.*

was well within the therapeutic range. Occasionally drugs which tend to prolong or augment the effect of the anticoagulant (eg, phenyramidol hydrochloride, phenylbutazone, salicylates, sulfonamides, etc.)[21,22] were involved.

Summary

Massive hemorrhage into the gallbladder is rare and usually associated with trauma, neoplasm, inflammation, calculi, or an aneurysmal vessel of the liver or gallbladder. Reports of anticoagulation therapy complicated by hemorrhage into a variety of tissues have been previously published but this appears to be the first case of hemocholecyst.

An elderly cardiac patient, on long-term bishydroxycoumarin therapy developed epigastric pain. Because an intra-abdominal lesion could not be definitely established, and because of the electrocardiographic and serum enzyme changes, he was treated for a myocardial infarction with continued anticoagulant administration. Three weeks later, signs of acute cholecystitis developed. At operation an inflamed gallbladder, containing gallstones and 300 ml. of blood, was found.

Hemorrhage associated with anticoagulants is characterized by: (1) The absence of an overt hemorrhagic tendency; (2) The rarity of skin and subcutaneous bleeding; (3) Its occurrence with several types of anticoagulants; (4) No definite relationship with duration or administration of dosage.

Generic and Trade Names of Drugs

Bishydroxycoumarin — *Dicumarol*
Vitamin K_1 (phytonadione) — *Mephyton*®
Phenyramidol Hcl. — *Analexin*®
Phenylbutazone — *Butazolidin*®

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HYPERVOLEMIA may follow intravenous administration of excessive volumes of fluid or blood or intravascular absorption of large quantities of irrigating solution from surgically traumatized venous sinuses. The latter may occur during transurethral surgical procedures. The following prophylactic measures have been recommended to minimize intravascular absorption of significant amounts of irrigating solution: (1) introduction of irrigating fluid under moderate hydrostatic pressure, with the reservoir height not over 28 inches above the bladder; (2) limitation of duration of the procedure to one hour; and (3) avoidance of dissection extending into the deep-lying sinuses. — The Anesthesia Study Committee of the New York State Society of Anesthesiologists, Lester C. Mark, M. D., Chairman: *New York State Journal of Medicine*, 66:979-980, April 15, 1966.

Spontaneous Internal Biliary Fistulas

Report of 12 Cases with Discussion

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FISTULAS between the biliary system and gastrointestinal tract are a serious complication of diseases involving the biliary system. A review of the literature reveals many cases of solitary fistulas and some scattered reports of simultaneous multiple fistulas. Armory and Barker[1] reported the details of three cases with multiple fistulas. The purpose of this article is to report the analysis of 12 examples of internal biliary fistulas and to review important features of these fistulas.

Incidence

Marshall and Polk[2] reported that the majority of fistulas occur in the sixth and seventh decades of life. The age of the patients who have spontaneous internal biliary fistulas corresponds closely with that of patients who have chronic cholecystitis and cholelithiasis. The incidence of fistula formation will vary from hospital to hospital, depending upon the number of patients undergoing biliary surgery and the various factors which lead to a delay in admission and management of patients with acute biliary conditions.

Puestow[3] found 16 instances of fistula formation in 500 operations for benign biliary disease or 3 per cent. Dean[4] noted that 1.2 per cent of patients with cholecystitis had fistulas. Mirizzi[5] reported 78 cases of fistulas in 2,613 cases undergoing biliary surgery or 3 per cent.

Pathogenesis

The occurrence of spontaneous internal biliary fistulas may be attributed to two principal causes: (1) chronic cholecystitis with or without concomitant cholelithiasis or choledocholithiasis and (2) penetrating duodenal ulcer.

Carcinoma of the gallbladder, biliary tree, and other organs rarely causes this condition. The pylorus and first part of the duodenum lie close to the common bile duct as it courses through the gastrohepatic ligament; this explains how a penetrating peptic ulcer may erode the common bile duct and lead to subsequent formation of fistulas.

According to Hicken and Coray,[6] 90 per cent of the fistulas between the gallbladder and intestine follow erosion or perforation by stones and are often accompanied by acute cholecystitis. In a small number of cases the gallbladder may rupture leading to pericholecystic abscess and secondary necrosis of the adjacent viscus and permanent fistula formation. (Foss and Sumner[7])

Judd and Burden[8] analyzed 153 cases and concluded that fistula formation occurred by direct penetration between adherent organs in 148 cases and via pericholecystic abscess in five cases.

Location of Fistulas

The internal biliary fistulas can be categorized into four common types: (Fig. 1)

1. Cholecystoduodenal fistulas (70 per cent);
2. Cholecystocolic fistulas (15 per cent);
3. Cholecystogastric fistulas (6 per cent);
4. Choledochoduodenal fistulas (5 per cent).

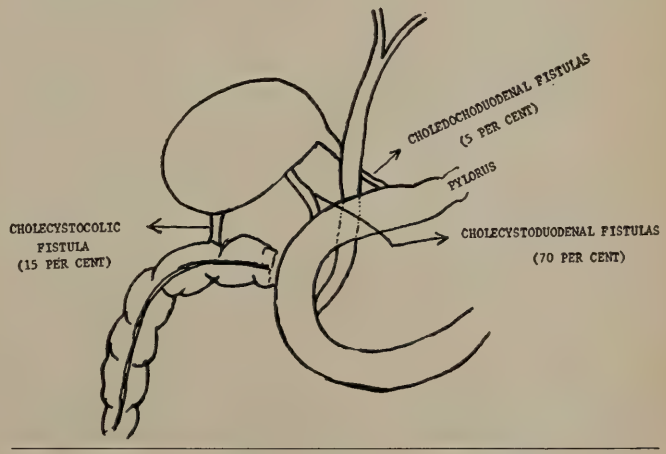


FIG. 1. *Common Types of Biliary Fistulas.*

Waggoner and Lemone[11] cited a higher incidence of choledochoduodenal fistulas in a review of large series of cases. Rare types of fistulas as cholecystoduodenocolic fistula[12] and cholecystohepaticochole-

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dochal fistulas account for 4 per cent of biliary fistulas.

Clinical Features

There are no distinctive findings diagnostic of spontaneous internal biliary fistulas. Most patients present a clinical picture of the primary pathologic process. Judd and Burden[8] reviewed the clinical findings of 153 operated cases. The average duration of primary disease in the biliary system was ten years. Recurrent episodes of biliary colic were noted in 85 per cent of the cases, colic and jaundice in 50 per cent, fever in 45 per cent, and obstruction of the common bile duct in 20 per cent. These findings are comparable to those of other series.[9]

Radiographic Findings

The direct sign of a fistulous connection is the presence of gas or contrast material in the biliary tree (Fig. 2). (Borman and Rigler.[10]) The indirect signs

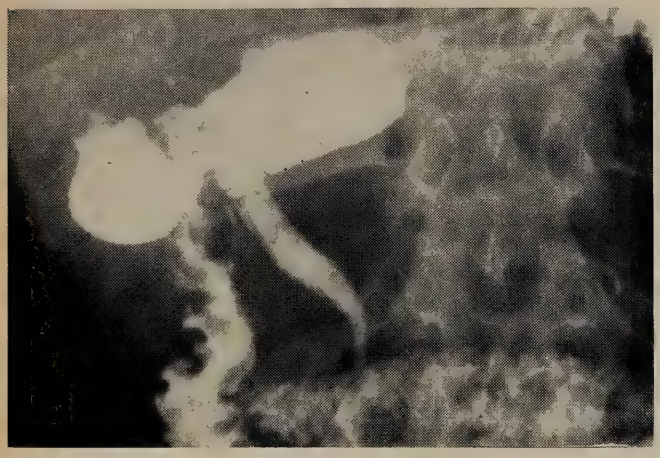


FIG. 2. *Barium and Air in the Common Bile Duct* (Case No. 9).

are nonfunctioning gallbladder with or without calculi.

In our series of 12 cases, 11 patients had nonfunctioning gallbladder with calculi and three had air in biliary tree on plain abdominal x-rays. Two cases had radiopaque contrast medium in biliary tree after a routine gastrointestinal study.

The gastrointestinal study should be performed as routine in most patients with long history of biliary system disease; it would assist in preoperative evaluation of patients for the presence of fistulas. (Pittman and Davies.[13])

Material Studied

A brief summary of 12 cases of internal biliary fistulas noted in 2500 patients with biliary system disease operated upon in Good Samaritan and Miami Valley Hospitals from 1960 to 1964 is presented in Table 1. The fistulas encountered were located as follows:

Cholecystoduodenal — 8
Cholecystocolic — 2
Choledochoduodenal — 2

Both patients with choledochoduodenal fistula had chronic duodenal ulcers, and one patient had a normal gallbladder on double dose cholecystograms. The second patient presented as perforated duodenal ulcer with choledochoduodenal fistula.

Management

Oftentimes internal biliary fistulas are not diagnosed preoperatively, and in some instances may not be suspected until the operation is well under way.

Every patient with chronic biliary system disease and long history of symptoms should undergo radiographic studies of the gastrointestinal tract. An unexplained shadow of air in the area of biliary passages and knowledge of the incidence of spontaneous fistulas should enhance one's suspicion as to the presence of these fistulas. Most patients with choledochoduodenal fistulas will have evidence of chronic duodenal ulcer with or without chronic biliary system disease.

Most cases of cholecystoenteric fistulas can be managed by performing cholecystectomy and closing the opening in the bowel. In some cases this may not be feasible due to densely adherent and stenotic gallbladder, in which case removal of part of the gallbladder and leaving the rest in the liver bed after chemical treatment to defunctionalize the mucosa will suffice.

Operative cholangiography can be of help in difficult cases. (Carlson and Byron.[15])

The operation of choice for choledochoduodenal fistulas due to eroding duodenal ulcer is subtotal gastrectomy and gastrojejunostomy. The fistula should be inspected by performing a duodenostomy. (Walker and Large.[16])

The surgeon should be aware of the presence of more than one biliary fistula and in such cases operative cholangiograms may be helpful. Patients should be treated with heavy dosage of penicillin and broad spectrum antibiotics.

Summary and Conclusion

1. Twelve cases of spontaneous internal solitary biliary fistulas are presented with review of the literature.

2. Patients with five or more years of chronic biliary system disease should have complete radiographic examination of the gastrointestinal tract, which might lead to an increase in the preoperative diagnosis of this entity.

3. The possibility of multiple internal biliary fistulas should be kept in mind, and exploration of the common bile duct and operative cholangiography should be considered in selected cases.

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TABLE 1. *Summary of 12 Cases of Internal Biliary Fistulas in Patients Operated Upon at Good Samaritan and Miami Valley Hospitals from 1960 to 1964.*

No.	Age	Sex	Clinical Features	X-Ray Findings	Operative Findings	Management	Complications
1	64	F	Right upper quadrant pain, tenderness RUQ, fat intolerance	Nonfunctioning gallbladder with calculi	Cholecystoduodenal fistula	Cholecystectomy and closure fistula	None
2	75	F	Right upper quadrant pain, heartburn, fat intolerance for 5 yrs., obesity	Nonfunctioning gallbladder; no stones	Cholecystoduodenal fistula	Cholecystectomy and closure fistula	None
3	78	F	Fat intolerance, indigestion, nausea — 8 yrs., obesity	Nonfunctioning gallbladder with calculi	Cholecystoduodenal fistula	Cholecystectomy and closure fistula	None
4	58	F	Pain right upper quadrant jaundice, fever, tenderness RUQ	Nonfunctioning gallbladder with calculi and choledocholithiasis	Cholecystoduodenal fistula	Cholecystectomy, choledocholithotomy, closure fistula, T. tube in C.B.D.	Ascending cholangitis
5	69	F	Pain RUQ, obesity, mass RUQ	Nonfunctioning gallbladder with stones	Cholecystoduodenal fistula	Cholecystectomy and closure fistula	Atelectasis rt. lung base
6	54	F	Pain in epigastrium, fat intolerance — 6 yrs.	Nonfunctioning gallbladder	Cholecystoduodenal fistula	Cholecystectomy and closure fistula	None
7	72	F	Pain RUQ, mild jaundice, chills and fever	Nonfunctioning gallbladder and stones	Cholecystoduodenal fistula	Cholecystectomy and closure fistula	None
8	69	M	Indigestion and fat intolerance, epigastric distress	Nonfunctioning gallbladder; no stones	Cholecystoduodenal fistula	Cholecystectomy and closure fistula,	None
9	48	F	Postprandial epigastric pain, hematemesis	Normal gallbladder; no calculi; air in biliary tree	Choledochoduodenal fistula and chronic duodenal ulcer	Billroth II; subtotal gastrectomy, T. tube in C.B.D.	None
10	64	M	Mass in epigastrium, episodes of chills and fever, jaundice	Nonfunctioning gallbladder; air and barium in biliary tree	Choledochoduodenal fistula; chronic duodenal ulcer — perforated and localized	Gastrojejunostomy; T. tube; choledochostomy	Hepatic failure; died
11	58	F	Temperature, RUQ pain, and tenderness RUQ	Nonfunctioning gallbladder and calculi; air in biliary tree	Cholecystocolic fistula and pericolic abscess; perforated diverticula	Drainage abscess	None
12	60	F	Pain RUQ, diarrhea	Nonfunctioning gallbladder and calculi	Cholecystocolic fistula	Cholecystectomy and closure fistula	None

Anomaly of the Gallbladder

Case Report of an Unusual Location

J. L. BILTON, M.D., and C. L. HUGGINS, M.D.

ANOMALIES of the gallbladder occur in number, form, type, and position. Gross,[1] in presenting 50 cases from the available literature up to 1936, stated that congenital anomalies of the gallbladder itself, bile ducts and vasculature excluded, were rare. Haines and Kane[2] reported only 76 present in the available literature, as late as 1946. Davis and Trower,[3] on agenesis of the gallbladder, after an exhaustive search of the literature, revealed the number of recorded cases to be no larger than 63, yet these were not all documented as to how thorough a search had been made to find the gallbladder in anomalous positions.

Anomalies of form and number are surgical curiosities which, with rare exception, seldom alter the natural course of gallbladder disease, or present any technical difficulty in removal, a possible exception being a double gallbladder in which the second unsuspected organ is buried in the liver itself. Gallbladders have been absent or found in the liver, the falciform ligament, and the abdominal wall. Reed, et al,[7] report a double gallbladder with two ducts.

Considering anomalies of position, the most often cited in the literature is the left-sided gallbladder. Next in frequency is the "floating gallbladder." Due to kinking of the cystic duct this anomaly is most often encountered as an emergency.

Regen and Poindexter[6] reported one such case in which the "free floating" cystic duct permitted a floating gallbladder (surrounded by peritoneum) to be located on top of the right lobe of the liver. Given a patient with gallbladder symptoms and x-ray diagnosis of no function, the operating surgeon must be aware of the existence of these abnormalities of location to avoid closing the abdomen in confused ignorance.

The purpose of this paper is to review a case wherein the gallbladder was located in the mesocolon.

Case Report

Mrs. —, a 59 year old Negro woman, was admitted to the hospital with a one year history of upper left quadrant abdominal pain, which was nonradiating, sharp, and constant. There was no positional relief of pain. The patient complained of intolerance to greasy foods and several episodes of nausea, with vomiting of bilious material. There was no history of jaundice, dark urine, or clay-colored stools. There was a history of a weight loss of 18 lbs. within the past year, and increased frequency of urination, with intermittent shooting pains down the posterior aspect of both legs.

Thirteen years ago the patient had x-ray therapy followed by a total hysterectomy for carcinoma of the cervix with no subsequent evidence of recurrence or metastasis. Incidental appendectomy was done.

Physical Examination: The patient was well developed and well nourished in spite of the weight loss. With the exception of tenderness to deep palpation in the left upper quadrant along the costal margin and fist-percussive tenderness in the left costovertebral angle, the physical examination was not remarkable.

Laboratory: Hemogram was within normal limits. Urinalysis showed 30 to 40 white blood cells, and many epithelial cells, with few bacteria. Blood chemistry was within normal limits. Intravenous pyelograms were within normal limits. Gallbladder series revealed nonvisualization.

Hospital Course: Following the diagnostic evaluation and clearing of the urinary infection, the patient was taken to surgery with a preoperative diagnosis of chronic cholecystitis and cholelithiasis. Where the gallbladder is usually found was a smooth undersurface of the right lobe of the liver. Palpation behind the liver did not reveal the gallbladder. A search of the falciform ligament was unfruitful. To rule out a gallbladder buried in the liver, the proximal portion of the common duct was exposed, in search of the cystic duct leading to this gallbladder. None was found. The common duct was then exposed down to the point where it becomes retroduodenal, and here a cystic duct was encountered that ran medially into the transverse mesocolon. This was hidden by the right half of the transverse colon. The mesocolon was opened and the gallbladder exposed (Fig. 1). Operative cholangiograms were taken, and there were no stones in the common duct. A cholecystectomy was performed in routine fashion and the patient had an uneventful postoperative recovery.

Discussion

The finding of the gallbladder in this position was interesting. Embryologically, according to Hamilton and Boyd,[4] the caudal portion of the original hepatic

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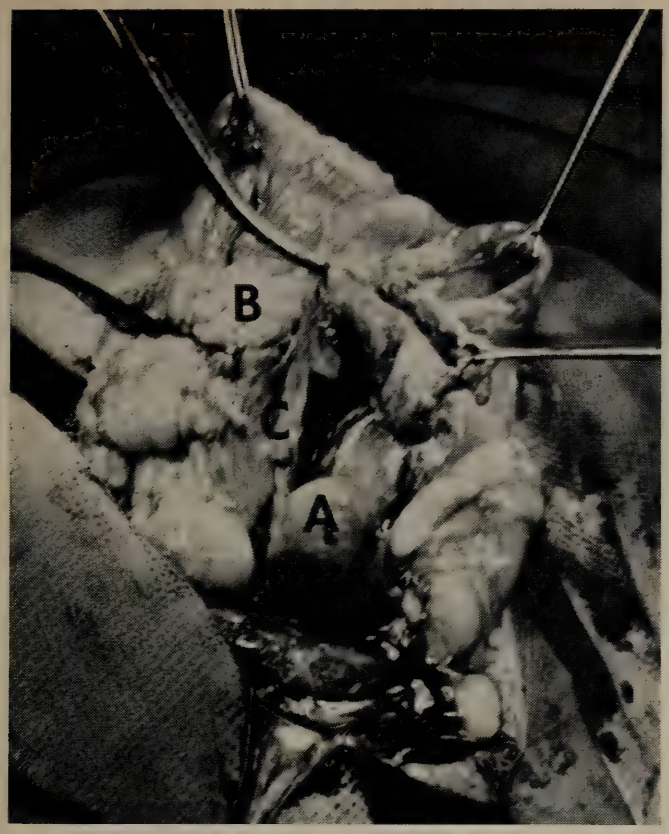


FIG. 1. (A) *Represents fundus of gallbladder;* (B) *Represents transverse colon;* (C) *Edge of mesocolon.*

bud becomes demarcated from the main hepatic mass. This portion (pars cystica) lies in the ventral mesentery and gives origin to the gallbladder and cystic duct. The single hollow stalk of attachment of the pars hepatics and the pars cystica to the duodenum elongates to form the bile duct and lies in the free edge of the ventral mesentery.

According to Arey,[5] the liver is enclosed by the ventral mesentery, and since the gallbladder was originally an analog of the liver, it can be suspended below the liver on a free mesentery. Gross postulates[1] it is this free state of suspension that allows migration of the gallbladder into its anomalous positions (left-sided behind the liver and free floating).

To reach a position in the mesocolon would necessitate migration through the epiploic foramen and into the omental bursa. (Arey[5] states that the openings are different, but for practical anatomic relations, they are the same.) Had this been the case, the cystic duct would have been found coursing through the foramen of Winslow, which was not the case.

Conclusion

Although anomalies of the bile ducts and vasculature are quite common, those of the gallbladder are not frequently reported.

Given a symptomatic patient with nonvisualization of the gallbladder, the operating surgeon must be aware of possible anomalous locations if the gallbladder is not found in its usual location.

In this case, it is conceivable that this symptomatic gallbladder might have been missed without a thorough exploration for a point of origin along the common duct.

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GALLBLADDER DYSPEPSIA. — An attempt has been made to determine what association, if any, exists between chronic dyspepsia and the presence of gallstones, determined radiologically in women aged 50 to 70 years. The survey was conducted in a general practice to avoid the selection inevitable in a hospital population. The women were interviewed before being x-rayed, so that their histories were not biased by any knowledge of whether gallstones were present or not.

A history of dyspepsia was obtained from 12 (50 per cent) out of 24 subjects with gallbladder disease. Of those with normal cholecystograms 63 (53 per cent) out of 118 had similar symptoms. The dyspepsia suffered by those with gallstones was not distinguishable from that experienced by those with normal gallbladders.

It is concluded that among women aged between 50 and 70 the occurrence of chronic dyspepsia and gallbladder disease is coincidental. These symptoms cannot assist in diagnosis of gallbladder disease and should not influence its treatment. — W. H. Price, M. B., B. Sc., M.R.C.P. Ed., Eastern General Hospital, Edinburgh, Scotland: *British Medical Journal,* pp. 138-141, July 20, 1963.

Hyperglobulinemic Purpura

Report of a Case and Review of the Literature

C. JOSEPH CROSS, M.D., W. A. MILLHON, M.D., J. S. MILLHON, M.D., and D. E. HOFFMAN, M.D.

IN 1943 WALDENSTRÖM first described the coexistence of purpura and hyperglobulinemia as a possible specific clinical entity.[1,2] The number of reported cases has increased rapidly since that time and a recent critical review of the literature has raised the question as to the validity of this concept.[3] It is the purpose of this report to review the clinical course of this condition, to report a case, and to consider the differential diagnosis with the intent of further establishing it as a distinct clinical syndrome.

Clinical Course

This condition has been described in all age groups and in both sexes with females predominating. It has an insidious onset, appearing first as an intermittent purpuric rash on the lower extremities, often after the wearing of constrictive clothing and after prolonged walking or standing. Purpuric areas may also occur on the arms, especially after mild traumatic episodes, on the lower trunk, and rarely on the soles of the feet.[4] The attacks may be entirely asymptomatic but more often they are associated with mild itching and burning and occasionally with pain and edema. Over a period of years the attacks occur with increasing frequency and severity but always follow a similar stereotyped pattern.

The rash is petechial, occasionally showing slight erythema, and develops in crops and patches which often become confluent. It progresses rapidly and reaches its maximum intensity within a few hours. Ecchymoses have not been observed. The area of the lesions develops a brown discoloration which may persist or gradually fade away. Little or no trophic change occurs in the skin, although the intensity of the discoloration may simulate a marked vascular deficiency.

The rise in the globulins is due to an increase in the gamma fraction of the S-7 type, the electrophoretic pattern showing the gamma fraction to have a wide base and a rounded apex. The albumin fraction is normal or low, the total protein is normal or high. There is no reported elevation in cryoglobulins and macroglobulins. The blood count may show mild anemia or leukopenia; the platelet count and coagulation studies are usually normal. A recent report has indicated an abnormality in the thromboplastin generation test as measured by the quantitative assay for platelet factor 3.[5] Capillary fragility may be normal or increased, and bone marrow studies are usually within normal limits, although benign increases in reticuloendothelial cells and plasma cells have occasionally been noted.

Histologically, the changes occurring during the early phase of the attack are those of a perivascular infiltration of small vessels in the dermis with acute and chronic inflammatory cells, associated with spotty arteriolar necrosis. Red cells are free in the dermis. After several days, the perivascular cuff is composed mostly of mononuclear cells, and there is iron in the macrophages and also free in the dermis.[6]

The following case is presented as fulfilling the diagnostic criteria for Waldenström's purpura hyperglobulinemia.

Report of Case

A 53 year old dental assistant was first seen on January 11, 1963 with a chief complaint of chills, fever, and increasing edema of her feet and ankles. This had had a rather acute onset 11 days before and was associated with marked

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frequency, dysuria, and nocturia. She stated that her "discolored" legs became a "brighter" red before the onset of the edema.

On questioning her about the history of this discoloration, she stated that she had had episodes of spotty purpuric eruptions on both legs below the knees for about 35 years. Initially they had been imperceptible, and she remembered them as being most pronounced when she was fatigued or after prolonged standing. These episodes were first noted in her late teens. She had been working as a dental assistant for 17 years and had noted a progressive increase in the discoloration during this period. The episodes were originally intermittent and asymptomatic and later were associated with mild tingling sensations. Her work at this time required her to stand for most of her working day. She had increasing discomfort, manifested by paresthesias and occasional stinging sensations. During the past six years the discoloration had persisted and remained as a permanent spotty, brown pigmentation, diffusely and symmetrically distributed over both lower extremities below the knees.

Prior to her present illness she had no episodes of edema. She had no cold sensitivity, no joint pain, and no known allergies. She admitted to no gastrointestinal or cardiorespiratory symptoms. She had had a right upper lobe segmental resection for a benign pulmonary cyst in 1953 with an uncomplicated recovery. Cessation of the menses occurred uneventfully in 1951.

Physical examination revealed an alert, asthenic 53 year old white woman. Temperature was 99.6, pulse rate 80 per minute, respiratory rate 24, and blood pressure 134/76. A right thorocotomy scar was present. There were no pulmonary or cardiac abnormalities. Abdominal examination was relatively normal except for mild tenderness over the suprapubic area. There was moderate to marked right costovertebral angle tenderness. Pelvic examination was normal except for slight inflammatory changes around the urethral meatus. Extremities demonstrated a diffusely symmetrical purpuric and slightly atrophic rash characterized by lightly scaling, pigmented areas in a somewhat annular arrangement. This phenomenon was present over the entire lower extremity below the knees. Neurological examination was normal, and there was a 2 plus pitting edema of the ankles, nontender and symmetrical.

Laboratory study revealed hemoglobin 13.8 Gm. per 100 ml., hematocrit 40 per cent, and leukocyte count 3,450 with 62 per cent neutrophils and 38 per cent lymphocytes. The erythrocyte sedimentation rate was 44 mm. per hour. Urinalysis showed a specific gravity of 1.026, pH of 7.2, protein 10 mg., glucose negative, and numerous leukocytes and epithelial cells, many bacteria, scattered erythrocytes and rare granular casts. Culture of urine yielded *Staphylococcus aureus,* which was sensitive to tetracycline and Gantrisin®. Repeat examination and urine cultures after 10 days of treatment were within normal limits. Blood urea nitrogen was 14.4 mg. per 100 cc., creatinine was 1.2 mg. per 100 cc., and urinary creatinine was 1.9 Gm. in 24 hours. Total protein (Howe method) was 8.2 Gm. with the albumin fraction 4.0 Gm. and globulin 4.2 Gm. Serology was nonreactive by the Kolmer, Kahn, and VDRL methods. The latex fixation test for rheumatoid factor was negative, the alkaline phosphatase measured 4.9 King-Armstrong units, the cephalin flocculation test was 1 plus, and the thymol turbidity measured 1 to 4 units. Urinary Bence-Jones protein was negative. The Sia test was negative.

Bone marrow examination was normal, showing no increase in plasma cells or reticuloendothelial elements. Coagulation studies were entirely within normal limits: the bleeding time (Duke) was 3 minutes, the clotting time was 8 minutes, platelet count was 196,000 prothrombin time of 90 per cent of normal, and the tourniquet test was normal. Electrophoresis of the serum at pH 8.6 gave the following values: albumin 4.8 Gm. per 100 ml., alpha 1 globulin 0.08 Gm. per 100 ml., alpha 2 globulin 0.20 Gm. per 100 ml., beta globulin 0.39 Gm. per 100 ml., and gamma globulin 2.48 Gm. per 100 ml. This was 38 per cent of the total (normal 12 to 18 per cent). Chest x-ray, electrocardiogram, upper gastrointestinal series, electroencephalogram and intravenous pyelogram were normal. Skin biopsy and ultracentrifuge studies were not performed.

The patient's presenting complaints rapidly cleared on antibiotic therapy. The edema disappeared, but the purpuric lesions remained unchanged.

Differential Diagnosis

The usual causes of hemorrhagic or purpuric disease include vascular weakness, defective function or number of blood platelets, faulty coagulation mechanisms of the blood, and abnormalities of the serum proteins. Except for certain rare or recently recognized disturbances which require special methods of study, the recognition of most purpuric conditions seen in clinical practice can be determined with six basic tests: (1) clotting time; (2) bleeding time; (3) clot retraction; (4) tourniquet test; (5) prothrombin time; and, (6) prothrombin consumption. In the differentiation of hyperglobulinemic purpura from other purpuric syndromes, both laboratory and clinical evidence must be used, and these are sufficiently clearcut to warrant the identification of this condition as a specific syndrome.

Vascular purpuras may be congenital (hereditary telangiectasia, pseudohemophilia) or acquired. Most of the acquired forms are readily recognized (defective tissue support, allergy, infectious and nutritional, ie, scurvy), but two of these especially warrant further discussion. In the nonthrombocytopenic form of purpura associated with joint or abdominal pain known as Schoenlein-Henoch's purpura, the cause is presumed to be allergic. There have been several reports indicating that serum globulins may be elevated.[7-9] It has been stated that these two conditions are not distinguishable on a laboratory basis,[3] and there may indeed be an overlap. However, by definition, Schoenlein-Henoch purpura involves mucous and synovial membranes, while hyperglobulinemic purpura does not, and skin involvement with Schoenlein-Henoch purpura is often more severe, appearing as erythema multiforme, bullous lesions, urticaria, and even tissue necrosis. Dermatologic changes in hyperglobulinemic purpura are more benign.

The other vascular conditions which should be discussed are those generally classified as the pigmented purpuric dermatoses of Schamberg and Majocchi. There are actually four closely related dermatological conditions included in this group: (1) Schamberg's progressive pigmentary dermatitis[10]; (2) angioma serpiginosium[11,12]; (3) purpura annularis telangiectodes of Majocchi[13]; and, (4) pigmented purpuric lichenroid dermatitis.[14] All of these have been separately described, but there have been questions raised as to whether these are simply variants of the same condition.

As protein studies have not been included in the reports on these conditions in the dermatologic literature, it is possible that many of these might be more properly classified as hyperglobulinemic purpuras of Waldenström. They have been characterized as benign and asymptomatic purpuric and pigmented lesions with obscure causative factors, and

even the most expert dermatologists admit that it is seldom possible clinically to determine the anatomic nature of the visible punctate lesions and that the primary vascular abnormality in each of these conditions is usually indistinguishable.[15] Certainly, future reports on these pigmented purpuric eruptions should include protein studies.

The laboratory manifestations of thrombocytopenic purpura, both in its primary and secondary classifications, are too well known and easily recognized to warrant further discussion in the differential diagnosis.

Blood coagulation factors are usually normal in reported cases of hyperglobulinemic purpura, although there appears to be some variability in the capillary fragility, and there has been one report previously mentioned of an abnormality in thromboplastin generation.[4]

In the category of dysproteinemias, there are again two diseases important in the differential diagnosis. The first is the purpura associated with cryoglobulinemia. The frequent coexistence of these two phenomena has suggested the term "purpura cryoglobulinemia."[16] These conditions are usually asymptomatic and may be accompanied by cyanosis, numbness of severe degree, Raynaud's phenomenon, vascular occlusions, hemolytic anemia, hemoglobinuria, chills, and fever. The presence of cryoglobulins in the blood and the history of precipitation by cold will usually easily differentiate this condition.[17]

It is interesting to note that cryoglobulins have been found associated with the other causes of hyperglobulinemia and purpura, which must be included in our list of differential diagnostic possibilities. They are identifiable by specific diagnostic tests and need only be listed. These include collagen diseases (systemic lupus erythematosis, polyarteritis nodosa, rheumatoid arthritis, and Sjögren's syndrome), chronic infections (syphilis, kala-azar, subacute bacterial endocarditis), chronic lymphatic leukemia, lymphosarcoma, sarcoidosis, and multiple myeloma. One case reported as purpura hyperglobulinemia subsequently terminated as multiple myeloma.[18]

The second dysproteinemia which must be considered is the macroglobulinemia of Waldenström. The eponym and similarity of name are confusing, but it is only rarely associated with purpura and is characterized by specific symptomatology. It is a disease of an older age group, ranging from 50 to 70 years, and is manifested by weight loss, undue susceptibility to infection, hepatosplenomegaly, lymphadenopathy, retinal hemorrhages, and bleeding from mucous membranes. Increased blood viscosity due to the macroglobulin may lead to congestive heart failure and certain neurologic disturbances

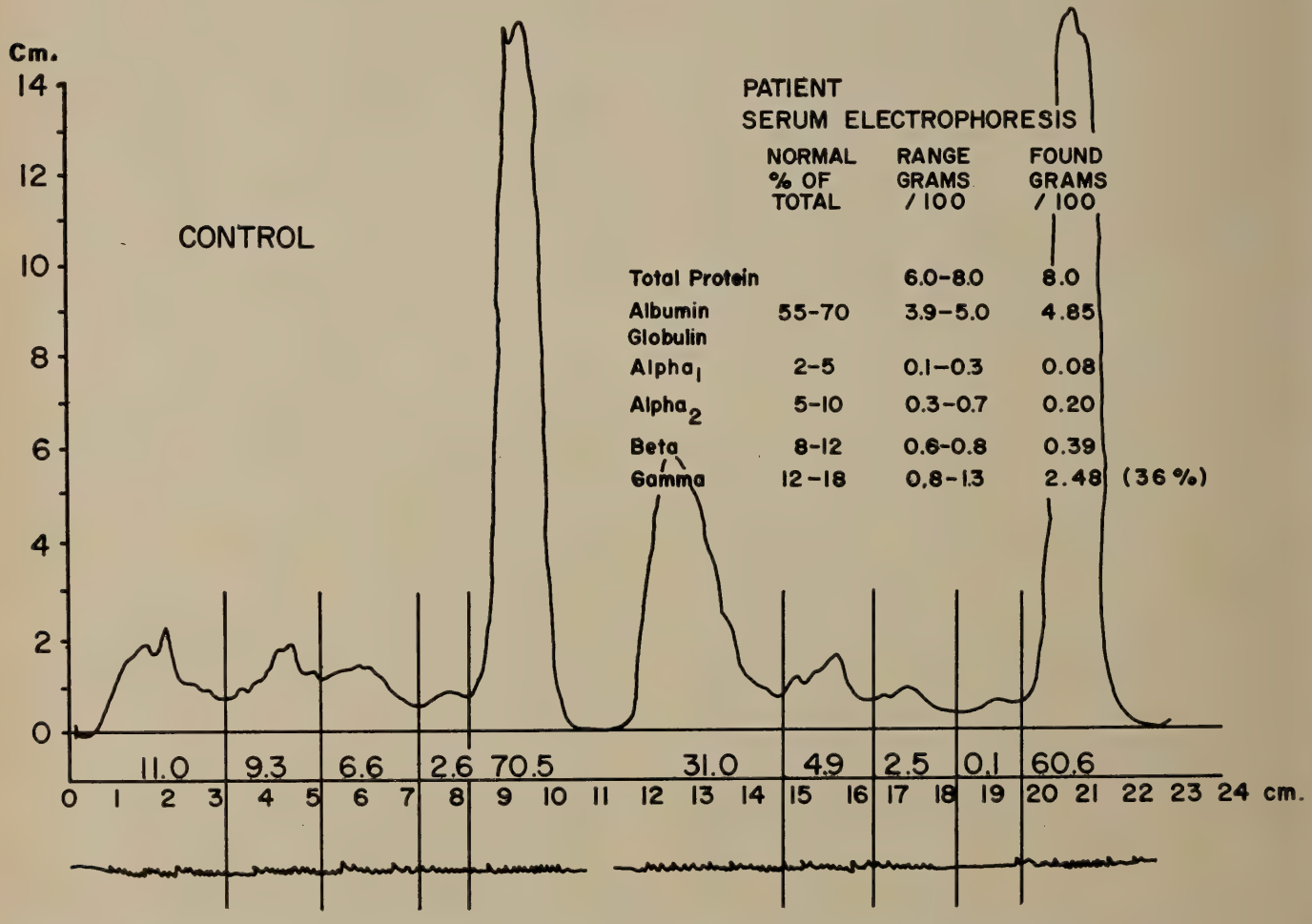


FIG. 1. *The serum electrophoretic pattern demonstrates the characteristic wide base and rounded apex of the markedly increased gamma fraction.*

(Bing-Neel). It may be identified by ultracentrifugation, and, if this is unavailable, the macroglobulin may be indicated by the Sia test and the dark "M" spot marking the paraprotein on paper electrophoresis.

Pathogenesis

The pathogenesis of the bleeding tendency in dysproteinemia remains obscure. Certain postulated mechanism can be readily ruled out, ie., thrombocytopenia due to the invasion of bone marrow by pathologic cells with subsequent crowding of the megakarocytes, as is seen in multiple myeloma. Specific abnormalities of the process of blood congulation are easily recognized and excluded by appropriate tests. A possibility that has been theorized is the infiltration of the vascular wall by the abnormal protein resulting in increased capillary fragility.[19] This alteration may be due to an allergic mechanism in the small vessel wall[20] or to the allergen altering the normal structure of the gamma globulins, which in turn affects the capillary endothelium.[21] Another theory has been that a chronic virus infection may stimulate the production of antibodies and increase the gamma globulin fraction of the serum.[22] This immuno-allergic mechanism is attractive but unproven.

Summary

The case of a 53 year old white woman with more than a 30-year history of purpura of the lower extremities and a relatively benign and asymptomatic course is presented. The presence of a marked increase in the gamma globulin fraction of the serum protein together with the absence of any apparent abnormalities in the coagulation mechanism coincide with the findings of Waldenström, who described this condition in 1942. The differential diagnosis and possible pathogenesis are briefly discussed. Although the validity of this syndrome has been questioned, the increasing number of reported cases with a distinct and reproducible clinical picture and laboratory findings appear to qualify this condition as a distinct clinical entity.

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THE ART OF MEDICINE during the past decades has been crowded into a role of less and less participation. This element pertains to the personal application of the science of medicine and that delicate, but so important, reaction brought into play by the physician-patient relationship; and, in contra-distinction to the *science* of medicine, the *art* cannot be passed on accumulatively from generation to generation. Rather, it must be learned anew by each neophyte of the medical profession. Just as the great artist carries with him to his grave the genius of those masterful strokes of brush on canvas, so is the art of medicine enfolded in the shrouds of the physician. — Melvin A. Casberg, M. D., Long Beach, (From an address at the installation of Granger E. Westberg as the first Dean of the Institute of Religion, Texas Medical Center, Houston, Texas, April 2, 1965), *California Medicine*, 104:381-386, May 1966.

Adenoma of Brunner's Glands

A Case Report

NOEL PURKIN, M. D.

ONE HUNDRED years ago, Cruveilhier published the first report of a duodenal tumor. Since that time, according to current reports, there have been only approximately 70 cases of adenoma of Brunner's glands of the duodenum recorded in the literature.[1] Hoffman[1] states that in a series of 66 cases of benign tumors of the duodenum, 10.6 per cent arose from Brunner's glands.

The etiology of this lesion is not known, but many theories have been conjectured. Cohnheim, for example, contended that these tumors arise from misplaced embryologic tissue with delayed new growth. Another hypothesis proposes that irritation and inflammation results in duodenitis followed by hyperplasia and thickening. A review of the literature reveals that there is usually a symptom triad of (a) hemorrhage, ie, melena and/or hematemesis; (b) irritation, resulting in epigastric pain and cramping; and (c) obstruction. The predominant sign is a duodenal filling defect on radiological examination, and the accepted treatment is surgical extirpation.[2]

Case Report

A 52 year old white man was admitted to the hospital complaining of shortness of breath. He stated that he had been having tarry stools, approximately two to three daily, for one month before admission. For the week previous to admission, he had experienced postural dizziness, lightheadedness, and dyspnea. He denied epigastric pain, nausea, emesis, or any previous ulcer history or radiologically proven ulcer. In addition, he denied that he was a chronic alcoholic, but this was later contradicted by a sister.

Physical examination revealed an alert, white man of stated age, apprehensive and well oriented. His skin, conjunctivae, and mucous membranes appeared pale, but he was not perspiring unduly. His oral temperature was 97.8°F., respiratory rate 20/minute, pulse 96 per minute and regular, and blood pressure 198/78 mm. Hg (left arm, dorsum recumbent). The abdomen was soft and nontender, with no masses palpable. The spleen and kidneys were non-palpable, and the liver was felt to be firm, 5 cm. below the right costal margin, with the dome of the liver percussed at the sixth interspace. Rectal examination revealed the presence of tarry stool, which was guaiac positive.

His admission hematocrit was 14 per cent with a hemoglobin of 4 Gm/100 cc. He received 4 units of blood shortly after admission, 2 regular units and 2 of packed cells, and his hematocrit rose to 24 per cent and then levelled off to 22 to 24 per cent over the next 48 hours.

Submitted December 16, 1965.

The Author

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Treatment with an acute ulcer diet was begun and he was given anticholinergic drugs and antacids.

Radiologic studies revealed a tumor mass in the upper duodenum, possibly having herniated from the stomach into the duodenum and thus being mucosal or submucosal (Figs. 1 and 2). The fasting blood sugar was 98 mg/100 cc, blood urea nitrogen 15 mg/100 cc, direct bilirubin 0.1 mg/100 cc and total bilirubin 0.7 mg/100 cc, albumin globulin ratio 4.0/2.0 Gm per 100 cc, alkaline phosphatase 1.1 units, and a bromsulphalein test showed 5 per cent retention in 45 minutes. After another 1000 ml blood transfusion, his hematocrit was 26 per cent, and he was taken to surgery nine days after admission.

At operation, a pedunculated globular mass, palpable at the pyloroduodenal junction was found. It was felt to be intraluminal. A longitudinal incision was made in the gastric antrum, and the tumor, measuring 2.5 inches in diameter, was delivered into the incision. Inspection of the tumor revealed marked nodularity and an ulcerated surface. The stalk was found to be on the gastric side of the pyloroduodenal junction, and it was severed at its base. The base was oversewn with 3-0 gastrointestinal chromic catgut. The gastric incision was closed in a transverse manner in two layers, using catgut and silk. The abdomen was closed without drains, with 2-0 braided wire interrupted sutures to the fascia.

The patient made an uneventful postoperative recovery, except for a rather wild episode in the immediate recovery room phase, which was felt to have caused a partial fascial dehiscence, noted and repaired under general anesthesia on the ninth postoperative day. He was discharged completely well on the seventeenth postoperative day.

Pathologist's Report: The surgical specimen consists of a grossly recognizable part of the duodenum, which is covering a pinkish tan solid tumor. The tumor and wall of the duodenum are densely attached to each other. One pole of the tumor (which is uncovered) appears to be reddish tan and somewhat lobulated, and this area is slightly friable. The specimen measures 5.7 cm long and 3.4 cm in average diameter. The duodenal wall is somewhat wrinkled and reddish tan in color. The cut surface is pinkish pale, and there are a few cystic areas which range from 0.4 to 0.9 cm in average diameter. Some mucoid material is seen on the cut surface. Microscopic examination of all sections reveal that there are numerous islands formed by an orderly proliferation of Brunner's glands with a scanty supporting stroma. The islands are separated from each other by loose, edematous, fibrotic tissue. In the islands, the acini are lined by a single layer of columnar cells

having flattened basal nuclei, pale granular eosinophilic cytoplasm, and a sharply demarcated basement membrane. Some acini are dilated, and evidence of cyst formation is present. The ducts are located in the interspace and are lined by cuboidal cells. In some areas, there is lymphocytic accumulation. The duodenal mucosa appears to be edematous. One section shows a thin capsule around the margin, implying that the tumor is completely removed.

Discussion

The occurrence of gastrointestinal hemorrhage invokes a wide differential diagnosis as to etiology. Providing intensive therapy early will allow specific diagnostic procedures; and many of the teleologic factors may be ruled out. In this case, the x-rays greatly enhanced the opportunity of making a more definitive diagnosis prior to operation. A review of the literature shows that this type of lesion is 100 per cent benign.

A middle-aged white man was admitted with evidence of gastrointestinal hemorrhage and signs and symptoms of marked anemia. There was an associated history of chronic alcoholism. He was given supportive therapy (intensive) allowing adequate investigation to be carried out. A duodenal mass was manifested on x-ray. At operation, a pedunculated, globular mass, intraluminal, was found at the pyloroduodenal junction. The tumor was markedly nodular and had an ulcerated surface. Following extirpation, the patient recovered and was discharged.

With current advances in surgical, radiological and



FIG. 1. *Gastrointestinal radiograph showing filling defect along lesser curvature of superior duodenum.*



FIG. 2. *Close-up of the duodenal filling defect.*



FIG. 3. *The tumor partially covered by duodenum.*



FIG. 4. *Cut surface of tumor showing cystic areas.*

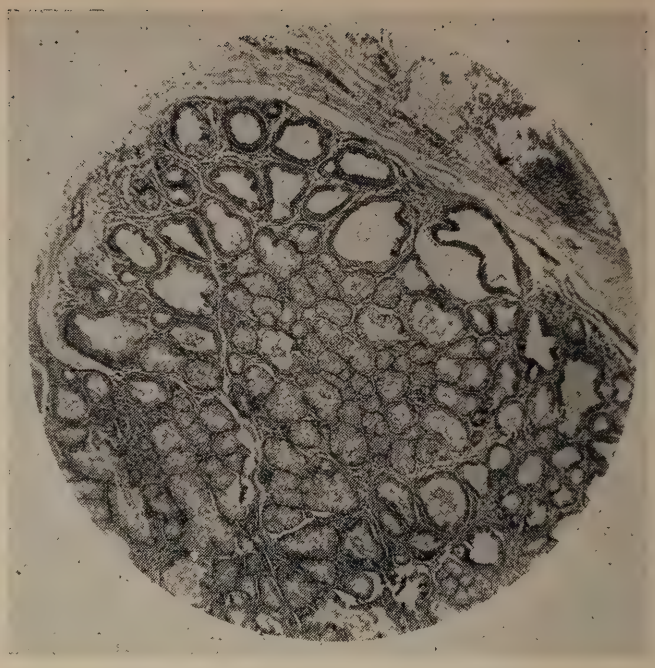


FIG. 5. *Microscopic section of tumor.*

therapeutic techniques, it is felt that an increasing proportion of duodenal tumors can be diagnosed and subjected to curative treatment. It is emphasized that frequently the presenting sign is gastrointestinal bleeding, either massive or prolonged, requiring intensive conservative therapy. The treatment, if effectual, can allow for elective surgery after the diagnosis has been established.

Summary

A case of adenoma of Brunner's glands has been presented with a review of the pathogenesis, symptom triad and treatment, plus the literature on this entity.

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PROCTOLOGY IN ANCIENT EGYPT. — Since physicians are men of learning, knowledge of medical history is a necessity, not a luxury. In the absence of a history of proctology, this essay hopefully provides some insight into the management of anorectal disorders mentioned in the medical papyri. Testifying to the quality of medicine practiced and recognizing the antiquity of the specialty of proctology, some of the knowledge passed along from ancient Egypt continues to influence present-day medicine. Enemas and suppositories are still in fashion. To unload their colons, people continue to take fruit, senna, colocynth and castor oil. The ancient Egyptians treated diarrhea, round and tapeworm infestations and bilharziasis; the medical specialists who treated anorectal disorders were held in especial esteem.

All these little known historical facts of our medical heritage should be better publicized to promote respect for the antiquity of our profession, to inspire a greater appreciation of this legacy from the past, and to provide moderation in evaluating our progress. — Leon Banov, Jr., M. D., Charleston, South Carolina: *Southern Medical Journal,* 58:1366-1369 (November) 1965.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

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- Emmerich von Haam, M. D., Columbus; Edited by Dr. von Haam.

PRESENTATION OF CASE

THIS white woman, aged 31, was in an automobile accident shortly before her admission to the hospital. She had been riding in the right seat of a half-ton pickup truck that was struck by a car on the driver's side. The truck overturned, landing on the right side. The patient remembered being thrown about in the truck and thought that she was struck in the left side of her abdomen. She did not lose consciousness. Immediately after the accident she vomited two or three times. When she was seen in the emergency room she complained of severe abdominal pain, the location of which was ill-defined. Initially it seemed to be in the left upper quadrant, then moved to the right lower quadrant, and then to the left lower quadrant. She also at times complained of back pain.

Her past history was significant in that she had poliomyelitis at the age of 3. This left her with multiple deformities, the most severe of which were a kyphorotoscoliosis of the spine and multiple deformities of the lower extremities. She had had at least 13 orthopedic procedures over the years, including multiple spinal fusions and multiple tenoplasties of her lower extremities. Other surgical procedures included three cesarean sections and one salpingectomy. She told of vomiting once or twice a week for the past seven years because of "sick headaches." Several months ago she had been seen at another emergency room claiming that she had vomited "coffee-ground" material.

Physical Examination

Her temperature was 98.6°F., her pulse rate 100 per minute, the respiratory rate 25 per min., and the blood pressure 120/80 mm. Hg. There was a severe left thoracolumbar scoliosis. The abdomen was protuberant and tympanitic. The patient complained of diffuse tenderness to palpation. There was no localization of the tenderness and no rebound tenderness. The bowel sounds were hypoactive. The rectal examination was negative; the stool was light brown and guaiac-negative. There were hematomas over the left lower tibial area and over the left olecranon process. Peripheral pulses were good. Numerous surgical scars were noted on the abdomen, the back, and on the lower extremities.

Laboratory Data

The initial laboratory studies showed a white blood cell count of 7,450 with a normal differential count; the hemoglobin was 13.7 Gm., the hematocrit 45 per cent. Urinalysis showed 3 plus sugar and positive acetone. The fasting blood sugar was 189 mg./100 ml. The blood urea nitrogen was 12 mg./100 ml. The serum electrolytes and amylase and the prothrombin time were normal.

X-ray films of the chest showed the previously noted marked scoliosis. The lung fields were clear, and no subdiaphragmatic abnormalities were identified. Supine and erect views of the abdomen showed the old spinal fusion grafts. It was felt that the pelvis was homogeneously dense, which was suggestive of a fair amount of peritoneal fluid. No free air was identified. A four-quadrant abdominal tap was negative.

Hospital Course

The patient was treated with nasogastric suction, intravenous fluids, and analgesics. As the nasogastric tube was passed, the patient vomited a small amount of dark material that was guaiac-positive.

There was little change of her vital signs throughout the night of her admission and by morning it was felt that she was stable. Her abdominal distention was somewhat less and there was less pain. The nasogastric tube was removed and she was given some oral fluids. As the day progressed, however, her pulse gradually increased until by afternoon it

Submitted July 21, 1966.

was 140 per minute; her blood pressure was 90 mm. Hg systolic. The hemoglobin at that time was 15.5 Gm. The serum amylase was 580 units. The nasogastric tube was reinserted and intravenous colloid and electrolytes were started. She did not respond to this treatment. Several hours later there was a rapid onset of respiratory distress. Her blood pressure was maintained at about 90 systolic with Neo-Synephrine®. Thoracentesis yielded a small amount of serous fluid from the left chest. The urinary output was 5 cc./hr. (specific gravity 1.022). Films of the abdomen taken at this time showed free air under the right diaphragm and it was felt that the pelvis was still homogeneously opaque.

Approximately 30 hours after admission the patient was taken to surgery. She died approximately 15 minutes after completion of the operation.

CLINICAL DISCUSSION

DR. THOMFORD: This is the case of a 31-year-old white woman who was injured in an auto accident and was admitted immediately thereafter to this hospital. Although the position in which the patient was seated in the automobile at the time of an accident and the direction from which the vehicle was struck are always of some importance, it seems that the most reliable information here is the fact that she herself thought the blow was to the left side of her abdomen. It became apparent that her problem could be looked upon as one of abdominal trauma and more specifically of blunt abdominal trauma as there was no open wound.

Blunt Abdominal Trauma

It is always disturbing to find that someone so young arrives in the emergency room with reasonably normal vital signs and then dies within 24 hours. However, one must recall that although the mortality rate of penetrating abdominal wounds has decreased from something like 65 per cent prior to World War I down to the present rate of approximately 5 per cent, the mortality from blunt abdominal trauma is still significant and if all cases of blunt abdominal trauma are included is as high as 40 to 50 per cent.

This rather frightening mortality rate can be, in part at least, attributed to the fact that multiple organ systems are usually involved in a blunt abdominal trauma, that is, there is often also trauma to the head and chest. In one series reported by Dr. DeBakey, 95 per cent of patients who had blunt abdominal trauma and who were dead on admission had associated trauma to the head or thorax or both. It is also true that blunt abdominal trauma usually injures more than one organ, and the mortality rate increases directly with the number of organs involved.

Before analyzing the case, I would just like to make a few additional comments regarding blunt injury to the abdomen. Liver trauma is probably the most common one sustained with a blunt abdominal injury. Other injuries well known to you all are traumatic pancreatitis, ruptured bladder, renal contusion, injury to the great vessels within the abdominal cavity, rupture of the diaphragm, and of course injury to the spleen. Injuries to the gastrointestinal tract as the result of blunt abdominal trauma tend to occur at points of fixation, that is, the duodenum, the ligament of Treitz, and the distal ileum. In addition, of course, there may be rupture of the stomach or perforation of the colon. Pain is the most reliable single symptom of abdominal injury. In general persistent, increasing pain — localized or spreading — is an indication for abdominal surgical exploration, as is the pain which occurs immediately, disappears, and then recurs.

Her past medical history suggests that she had a migraine type of headache and certainly she had had a number of operations to correct the deformities produced by poliomyelitis. We are not told whether or not she was pregnant at the time of her accident, but we presume that she was not. She also had a history of possible hematemesis on one occasion and one might conclude from her past medical history that she might have had a peptic ulcer in the past.

Immediately following the accident she vomited two or three times and complained of severe abdominal pain. She also complained of back pain, but one might attribute her back pain to the fact that she had had numerous operations on the vertebral column and now was involved in a serious and severe accident. Her pulse was 100, but her other vital signs might be considered normal. She did have severe left thoracolumbar scoliosis, and the abdomen was protuberant, tympanitic, and diffusely tender to palpation but without any masses.

The negative rectal examination is of some importance since, as you know, patients with blood within the peritoneal cavity sometimes have rectal tenderness as one of the manifestations of this blood. The white blood count was within normal range, and this is of course of interest. In approximately 80 per cent of patients with injuries to the liver and spleen there will be leukocytosis. The hemoglobin and hematocrit would be considered normal. The fasting blood sugar was 189 mg., I believe, the BUN 12 mg., and the urinalysis was reported as showing 3 plus sugar and positive acetone. The electrolytes, prothrombin time, and the serum amylase were normal.

X-Rays

The chest films were said to be unremarkable, and in the x-rays of the abdomen the only abnormalities pointed out were those that were secondary to her operations upon her spine, showing the old spinal fusion grafts. However, it is said that the pelvis was homogeneously dense and suggestive of a fair amount of intraperitoneal fluid. No free air was identified, apparently. A four-quadrant abdominal tap was negative, and the patient was admitted to

the hospital for observation at that time. May we see the x-rays taken at the time of admission?

DR. HARRIS: There was some increased density in her pelvis which was of questionable significance since intraperitoneal fluid wasn't proved by the four-quadrant tap. Of interest was the film taken on the next day, at which time there was a large amount of free air under the diaphragmatic leaflet. Another bunch of gas bubbles seems to be fairly well localized in the right upper quadrant in a somewhat perirenal distribution, suggesting either an abscess or the presence of retroperitoneal and intraperitoneal air. The distribution of the air over the right perirenal area suggests perhaps a rupture of the third portion of the duodenum. A film taken post mortem on the next day showed similar findings.

Now just a few words about the intraperitoneal free air. This of course would be most common with a perforation such as has been already described. It is essentially the same as in mesenteric infarction although the gas pattern otherwise is not diagnostic of such.

In summary then, this patient had a fairly normal looking abdomen on the day of admission, but on the second day developed free intraperitoneal and retroperitoneal air in the right perirenal area suggesting a possible intraperitoneal as well as retroperitoneal perforation.

DR. THOMFORD: Thank you. She was started on nasogastric suction and given intravenous fluids, of what type and amount we are not sure, nor are we told what type of analgesics she had. There was little change in her vital signs throughout the night of admission. I think one should bear in mind in patients with blunt trauma that the pulse tends to remain normal when the liver has been ruptured. I do not know the physiologic explanation for this, but it has been pointed out by more than one observer. By morning it was felt that her condition was reasonably stable, but later in the day she developed tachycardia and hypotension. Her hemoglobin had increased rather than decreased, and the serum amylase was now elevated.

Respiratory Distress

She did not respond to intravenous colloids and nasogastric suction and suddenly respiratory distress developed. I suppose in anyone who has been in an auto accident, even though the admission films were normal, the appearance of sudden respiratory distress should suggest the possibility of a pneumothorax. She did not respond to the administration of Neo-Synephrine, and a thoracentesis yielded only a small amount of serous fluid from the left chest. We can only speculate as to why this thoracentesis was done. Perhaps they considered the possibility that she might have lacerated or ruptured her esophagus secondary to the retching on the day of admission. Her urinary output decreased to 5 cc. per hour, and x-rays of the abdomen revealed free air under the diaphragm. An operation was performed but the patient died 15 minutes following completion of the operation.

It always seems safest to me when seeing a patient with blunt abdominal trauma to consider injury to any and all of the major intra-abdominal structures and I did this in this case. It seemed unlikely that there was any injury to the major vessels within the abdomen since there was no definite evidence of blood within the peritoneal cavity and there was no palpable mass. The peripheral pulses remained normal and the hemoglobin increased rather than decreased during the first 24 hours. It seemed also unlikely that there was any extensive damage to the liver or spleen since again there was no definite evidence of blood within the peritoneal cavity and the hemoglobin did not decrease, and there was no shoulder pain or rectal tenderness, and there was no leukocytosis.

Injury to the urinary tract I think is reasonably well ruled out by the fact that there was no hematuria and there was no flank mass and no external evidence of flank injury. I think it unlikely that there was any traumatic pancreatitis. The amylase was normal on admission, the blow was to the left abdomen rather than to the epigastrium, and I would tend to explain the elevated amylase on the day following admission by the fact that the contents of the proximal gastrointestinal tract had been leaking out into the retroperitoneum or into the peritoneal cavity.

It does seem certain that there was a rupture of the gastrointestinal tract, and with the severe pain that was described and also since the pain appeared in the upper abdomen initially, I would speculate that the perforation probably occurred in the proximal gastrointestinal tract. This would be supported too by the fact that the fluid aspirated from the patient's stomach or the fluid she vomited was guaiac-positive. The fact that the pain was severe suggests to me that it was high in the gastrointestinal tract because the intraluminal contents there are more irritating to the peritoneal cavity than are those in the lower gastrointestinal tract.

We postulated that she had a perforation of the duodenum or proximal jejunum, but it seems unlikely that she should have died so rapidly from this injury alone since she was young and I would have thought that she would at least have been resuscitated temporarily. However, her clinical course immediately prior to operation suggests to me that her injury may have been complicated by one or both of two things — either diabetic acidosis with coma or by a Gram-negative septicemia and bacteremic shock. We are not given any information whether she was thought to be a diabetic or whether she was treated with insulin, but she did have sugar and acetone in the urine and the symptoms of tachycardia, hypertension, and Kussmaul respirations suggestive of

diabetic acidosis. And of course since she did have a perforation of the gastrointestinal tract one would have to consider bacteremic shock. So I would sum up this woman's injury, clinical course and death by saying that she did have traumatic perforation of the duodenum which secondary diabetic acidosis and/or Gram-negative bacteremic shock.

General Clinical Discussion

QUESTION: It is not particularly applicable to this particular case, but how often would you see the next day after four-quadrant taps enough free air to make it questionable whether it was introduced at the time of paracentesis or was due to rupture?

DR. THOMFORD: Well, she had a large amount of free air in the peritoneal cavity. Had there been a small amount — I suppose one-fourth the amount we saw on her x-ray — I would have thought that it was just possible that the air might have been introduced by the abdominal tap.

QUESTION: What did you make of the opacification in the pelvis? Would you have considered a culdocentesis?

DR. THOMFORD: No, I would not have considered a culdocentesis. I do not know the significance of what I see there, but I do not think that it is pathognomonic of anything and apparently our radiologists did not either. It was noted but it was not thought to indicate any particular pathology. It might be suggestive of intraperitoneal fluid.

QUESTION: Maybe it was retroperitoneal hemorrhage?

DR. THOMFORD: Yes, although I would think that unlikely. She did not have a fracture of the pelvis. If it was retroperitoneal hemorrhage I would have expected that there might have been some red blood cells in her urine as the result of contusion of the ureter or bladder.

QUESTION: Why wouldn't you have considered culdocentesis after the x-ray?

DR. THOMFORD: I think probably because there seemed to be enough symptoms, signs, and laboratory information to direct your therapy without doing culdocentesis.

QUESTION: Dyspnea was given as the important symptom terminally. I wonder whether the x-ray sufficiently eliminated the possibility of a ruptured bronchus or a spontaneous pneumothorax.

DR. HARRIS: The chest film showed free air beneath the diaphragm only. The compression on the lung by the elevated diaphragm and her scoliosis were considered sufficient reason for her respiratory distress.

QUESTION: I was concerned with her spleen. Dr. Thomford said there was no blood in the peritoneum and no leukocytosis, and I wasn't sure what he meant. I wondered if it would be possible to have a symptomless rupture or tear of the spleen.

DR. THOMFORD: Yes, I think it is perfectly possible that she had an injury to the spleen but I do not think that it caused her death. I think that if she had a splenic injury with hemorrhage into the peritoneal cavity sufficient to cause hypotension and produce the peritoneal signs that were described, we might well have found blood on the peritoneal tap. I think it unlikely that a splenic injury was the cause of her death.

QUESTION: How often would you get rupture of a viscus after you have a negative x-ray for air under the diaphragm and 24 hours later get this large amount?

DR. THOMFORD: I can't answer that in terms of percentage. Perhaps someone in the audience knows of a recent paper or statistic.

DR. NICK: There are no recent papers, but there have been reports that with perforated ulcer up to 50 per cent of the people may not show free air.

DR. THOMFORD: That's true of perforated ulcer, but I think traumatic rupture of the gastrointestinal tract would probably be a different problem.

QUESTION: What do you think of the possibility of a volvulus or a diaphragmatic hernia in a person with multiple operative incisions having a blunt trauma to her abdomen?

DR. THOMFORD: I don't think that diaphragmatic hernia should be any more likely in this patient than in any other. She did not have a congenital abnormality of her skeleton but one produced by poliomyelitis.

CLINICAL DIAGNOSIS

1. Abdominal trauma due to automobile accident:
   (a) Ruptured abdominal viscus.
   (b) Severe generalized peritonitis.
   (c) Septicemia.
2. Diabetes.

PATHOLOGIC DIAGNOSIS

1. Traumatic perforation of the duodenum.
2. Infarction of the ileum, cecum, and ascending colon.
3. Acute purulent peritonitis.
4. Diabetes mellitus.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: Since the patient was operated on, it would be wise to learn first what the findings were when they opened up her abdomen.

DR. BLACKWOOD: Under local anesthesia a left paramedian incision was made. The cavity was opened and contained a large amount of free air and fecal material. During this time the patient was moribund. On examination of the bowel, the small

bowel appeared dead from the proximal jejunum to the midtransverse colon. There were several loops of black bowel. Examining the distal duodenum, they did not find a perforation. The pancreas appeared to be free of any injury. There was a hematoma at the root of the mesentery. The surgeon felt that she probably hemorrhaged into the mesentery and that this caused vascular occlusion of the small bowel and proximal colon. They did not resect any bowel but closed her up.

DR. VON HAAM: This is a very interesting case, which we could discuss ad infinitum. The autopsy showed two lesions in this patient; one of them was the lesion discovered at surgery, which consisted of a severe gangrene of the ileum, the cecum, and the ascending colon, and the other lesion was a perforation of the first portion of the duodenum at the place where most of the injuries occur by bursting from increased pressure. The mesentery showed a hemorrhage which was really not severe. There were 300 cc. of liquid fecal material in the peritoneal cavity, and there was obviously a recent peritonitis. No severe hematoma was present.

Duodenal Perforation and Ischemic Bowel

The perforation of the duodenum was small and located on the posterior wall of the first loop of the duodenum. It was covered by fibrin and led into a sac which was walled off by fibrinous exudate. It was a rather sharply demarcated perforation, and there was no excessive bleeding. It had obviously occurred some time before the rest of the intestinal lesions. The latter can be classified as recent gangrene of the bowel. The wall of the bowels had a mottled appearance which extended over the entire jejunum, cecum, and part of the ascending colon. The process was not sharply demarcated but sort of gradually started at the lower jejunum and faded out towards the hepatic flexure of the colon. Although the jejunum was completely gangrenous, its wall was not congested at all. It was an ischemic necrosis as you find in typical mesenteric artery thrombosis.

The same lesion was present in the colon. Again there was complete ischemia with very early necrosis suggesting an interference with the arterial rather than with the venous circulation. The mesentery of this area showed marked distention of all small vessels but very little hemorrhage. There was no free blood or blood clots present, and the dusky discoloration of the mesentery could only be explained by the severe congestion in those very dilated vessels. The pancreas was normal, although ischemic, but there was no traumatic pancreatitis.

The patient died in severe shock and developed pulmonary edema, each lung weighing over 800 grams. The bronchi and the larynx contained gastric material from aspiration during her frequent vomiting, but the lungs did not show the typical aspiration pneumonia. The adrenal glands also showed the changes of severe shock. The patient was an old polio patient and section of her spinal cord showed vast empty areas of gliosis. The lesion was very extensive, bilateral, and involved the entire thoracic spinal cord and extended upward into the cervical cord. Her muscles showed the changes typical of extensive poliomyelitis.

To comment on the relative importance of the two abdominal lesions, we can state that either lesion was fatal. The perforation of the duodenum was in the process of being walled off and it was not discovered by the surgeons because it was located in the posterior wall of the duodenum. This type of injury is quite common in blunt trauma to the abdomen; in fact, 10 per cent of all blunt injuries to the abdomen will injure the intestine. The jejunum is the bowel most frequently injured, followed by the loose part of the duodenum. We have three different explanations for its occurrence: It can be due to crushing of the bowel against a solid mass, usually the vertebral column. This is observed more frequently in thin people than in obese individuals, and our patient had definitely a predilection for it because of her scoliosis. This kind of crushing injury leads to very ragged, large lesions which often produce a complete transection of the duodenum.

The second type of injury is produced by bursting whenever the sudden increase in the intraluminal pressure causes a bursting of the intestinal wall. This leads to small perforations resembling a "blow-out." These lesions can be found after bombing accidents where the pressure wave is definitely transmitted to the air in the intestinal tract. The lesion is usually characterized by a symptom-free interval which may sometimes last as long as two days. This mechanism looks the more likely explanation in our case, particularly since the patient's kinked bowel may very well have predisposed her to this type of injury. The last and rarest type of lesion is that produced by stretching of the intestine due to distortion of the body. Typical lesions occur principally in the esophagus and the rectum.

Traumatic Vasomotor Dysequilibrium

Although our patient had this perforation, we do not consider it the fatal lesion. Definitely fatal, however, was the gangrene of the large bowel. A very careful investigation at the autopsy table revealed no thrombus either in the veins or in the arteries. Of course we would not expect any thrombus in the veins because in that case the bowel wall would have been hemorrhagic rather than ischemic. So it must have been an arterial injury and have been caused by a so-called traumatic vasomotor dysequilibrium. This consists of either severe post-traumatic angiospasm or post-traumatic vasodilatation. The post-traumatic angiospasm is of sudden onset. It may last for hours at a time, and it may lead to lesions of ischemia. It has been blamed for certain lesions in

concussion of the brain and in trauma to the kidneys. Certain individuals are more sensitive than others to this type of condition. The post-traumatic vasodilatation is less common and has been particularly observed in cases of crushing trauma to the legs.

Another type of lesion which may follow trauma is of course thrombosis caused by dilatation of the vessels, drop in the blood pressure during shock, compressional injury to the vessels by hematomas, and by certain changes in the clotting mechanism such as hemoconcentration. Post-traumatic thrombosis is less frequent than post-traumatic angiospasm or vasodilatation, and I feel that we are dealing here indeed with a case of such post-traumatic vasomotor dysequilibrium. We realize that when we make such a diagnosis we must be sure that everything else has been excluded.

Positive proof of this diagnosis is extremely difficult since spastic vessels look exactly like normal vessels after death. However, in the absence of a hematoma of any kind or of any thrombosis, I can only explain her bowel gangrene as the result of post-traumatic angiospasm, particularly since the mucosal necrosis was so rapid and so complete. However, if somebody disputes this diagnosis I cannot disprove his argument. Postmortem culture showed normal intestinal flora in the peritoneal exudate and no organisms in the blood stream. The patient did not have any septicemia and obviously died of shock; first, primary shock and then secondary shock due to the onset of her gangrene.

So in conclusion, I feel that the patient had a traumatic perforation of the posterior wall of the first portion of the duodenum and extensive gangrene of the bowels due to the post-traumatic angiospasm.

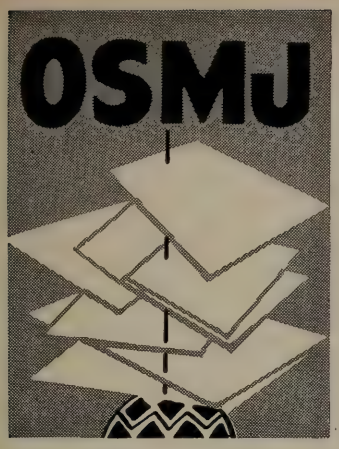
EDEMA OF THE ARM following radical mastectomy is due to a combination of factors rather than to a single cause. The primary factors seem to be lymphatic obstruction due to surgical excision or destruction by radiotherapy or phlebitis with perivenous lymphangitis and infection. Postsurgical edema must be differentiated from edema due to recurrence of cancer in the axilla.

Clinically, postmastectomy edema manifests itself in one of four types, each of which has different etiologic factors, therapy, and type of response: (1) acute transient, mild edema occurring immediately postoperatively; (2) acute, painful, transient edema manifesting itself usually two to six weeks after operation; (3) acute, painful, recurrent, febrile, erysipeloid edema occurring at any time after surgery; and (4) insidious, painless (except when severe), persistent edema, which is the most important type and which develops weeks or even years after surgery.

When edema develops, early intensive care is mandatory to avoid the development of permanent pathologic changes. In appropriate cases, lymphangiography and venography are valuable aids in determining the specific etiology of the edema.

Each clinical type of edema has different therapy and type of response. The most important type of insidious, painless, persistent edema has been treated by numerous surgical procedures with variable reported results. We have had excellent results using a pneumatic compression machine followed by the use of a custom-fitted, pressure-gradient elastic sleeve in 27 patients with significant to severe edema. — Henry Patrick Leis, Jr., M. D.; Warner F. Bowers, M. D., Ph. D., and Joseph Dursi, M. D., New York: *New York State Journal of Medicine,* 66:618-624, March 1, 1966.

BROTH EDEMA. — Two infants had generalized edema after treatment of diarrhea with bouillon broth. The hazards of feeding large amounts of such broth to infants are considered to be related to its high sodium content. — Captain Fred M. Nomura, Jr., M. C., USAR: *The New England Journal of Medicine,* 274:1077-1078, May 12, 1966.



NEWS AND Organization Section

Disaster Institute Program...

Planning for Management of Mass Medical Emergencies To Be Theme at Columbus Meeting, Sunday, October 30

A Diaster Institute Program is scheduled in Columbus on Sunday, October 30, for all persons interested in the specific theme "Planning for the Management of Mass Medical Emergencies." Sponsoring organizations are the Ohio State Medical Association, the Ohio Hospital Association, Ohio Department of Health, the Ohio Osteopathic Association of Physicians and Surgeons, the American Red Cross, and the Ohio Civil Defense Service.

Place is the Neil House, downtown Columbus hotel, with registration opening at 8:00 A. M. and the first program feature at 9:30. Adjournment time is 4:00 P. M. The program has been announced as follows:

Morning Session

Registration

Greetings

William Slabodnick, President, Ohio Hospital Association, Administrator, Fisher-Titus Memorial Hospital, Norwalk

Introduction and Setting the Theme

Roger Marquand, Chairman, Ohio Hospital Association Disaster Preparedness Planning Committee, Administrator, Polyclinic Hospital, Cleveland

"My Organization's Role in Disaster Management"

Medicine

Lawrence C. Meredith, M. D., President, Ohio State Medical Association, Elyria

Civil Defense

Dr. Alfred E. Diamond, Ohio Civil Defense, Columbus

Hospitals

James O. Helland, Administrator, Defiance Hospital, Defiance

Red Cross

Alfred L. Baron, Executive Director, Franklin County Chapter of Red Cross

Ohio Department of Health

Albert E. Dyckes, Chief, Division of Administration

Ohio Department of Public Welfare

Robert B. Canary, Assistant Director, Ohio Department of Public Welfare

"What Are the Problems?"

Keynoter

Roger Marquand will be noting that speakers to follow will be talking on disasters which could occur in Ohio (i. e. Tornado or plant explosion).

Jackson, Mississippi Tornado

C. E. Wallace, M. D., Chairman, Disaster Planning Committee, Central Medical Society, Jackson, Mississippi

Mr. Richard H. Malone, Administrator, Hinds General Hospital, Jackson, Mississippi

Morning Break

DuPont Explosion, Louisville, Kentucky

William Rumage, M. D., Member, Committee on Disaster Medical Care, American Medical Association, Chicago

"Here's How Your Problems Can Be Solved"

Communications

Lt. William H. Hildebrand, Asst. Director of Civil Defense, Alameda, California

Transportation

Franklin V. Wade, M. D., F. A. C. S., Chief, Section for the Surgery of Trauma, Hurley

(Continued on Next Page)

(Disaster Institute — *Contd.*)

Hospital; Chairman, Committee on Trauma, American College of Surgeons, Flint, Michigan

Medical Authority

Francis C. Jackson, M. D., F. A. C. S., Chief Surgeon, Veterans Administration Hospital, Pittsburgh, Pennsylvania; Chairman, Committee on Disaster Medical Care, American Medical Association

Lunch and Exhibit Break

Four Workshops

(Faculty will rotate every half hour)

How One Committee Does it

Franklin County Disaster Program, Philip Taylor, M. D., Group Leader

Ben Carlisle, Ohio Hospital Association

Communications

Lt. William H. Hildebrand, Group Leader

Max E. Knickerbocker, OHA

Medical Authority

Francis C. Jackson, M. D., Group Leader

W. Michael Traphagan, OSMA Staff

Transportation

Franklin V. Wade, M. D., Group Leader

Andreas Heuser, Red Cross Staff

For additional information and registration forms, contact W. Michael Traphagan, Secretary, Committee on Disaster Medical Care, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

Sixth District Postgraduate Day Scheduled in Akron, Oct. 19

The Sixth Councilor District Postgraduate Day clinical sessions, comprised of nationally renowned medical educators will be held at the Sheraton-Mayflower Hotel in Akron, on Wednesday, October 19. Registration will be from 8:30 to 9:30 A.M. on the first floor of the hotel, and the remainder of the program will be conducted completely on one floor. Cost of registration will include luncheon and parking facilities.

Advance registration is being arranged via a mailing of programs and advance registration cards to members of the Sixth Councilor District. The program has been announced as follows:

9:40-10:30 A. M.

Inguinal Hernia, Dr. Chester B. McVay, clinical professor of surgery, University of South Dakota — Cincinnati Room;

Heart Failure, Dr. James V. Warren, professor and chairman, Department of Medicine, Ohio State University School of Medicine — Ballroom;

(Sixth District — *Contd.*)

Pediatric Panel, Dr. Morris Green, associate professor of pediatrics, Indiana University Medical Center; Dr. Ernest K. Cotton, assistant professor of pediatrics, University of Colorado Medical School; Dr. Robert H. Parrott, director, Childrens Hospital, Washington, D. C. and clinical professor of pediatrics, George Washington University — Ohio Room;

10:40-11:30 A. M.

Amniocentesis for Prediction of Erythroblastosis Fetalis, Dr. Richard W. Stander, associate professor, Department of Obstetrics and Gynecology, Indiana University Medical Center — Cincinnati Room;

Medical Surgical Panel, Dr. McVay; Dr. Edmund B. Flink, professor of medicine and chairman of Department of Medicine, West Virginia School of Medicine; Dr. Roger B. Hickler, assistant professor of medicine and director of Hypertension Laboratory, Peter Bent Brigham Hospital; Dr. Lester Dragsted, research professor of surgery, University of Florida; Dr. James V. Warren, professor and chairman, Department of Medicine, Ohio State School of Medicine; Dr. Desiderius Emerick Szilagyi, head, Division of General Surgery, Henry Ford Hospital—Ballroom.

Behavorial Problems of Childhood, Dr. Cotton — Ohio Room.

11:40-12:30 P. M.

High Risk Obstetrics, Robert E. L. Nesbitt, Jr., professor and chairman, Department of Obstetrics and Gynecology, College of Medicine, State University of New York, Upstate Medical Center — Cincinnati Room;

Duodenal Ulcer, Dr. Dragsted — Ballroom;

Respiratory Distress Syndrome in Newborn, Dr. Cotton — Ohio Room.

12:40-2:00 P. M. — Luncheon - Ballroom

2:10-3:00 P. M.

Endometriosis, Dr. Carl T. Javert, professor, clinical obstetrics and gynecology, Columbia University — Cincinnati Room;

Diagnosis, Treatment and Prevention of Viral Diseases, Dr. Parrott — Ballroom;

Renin and Aldosterone Relationships in Hypertension, Dr. Hickler — Ohio Room.

3:10-4:00 P. M.

Abortion — Body Types — Emotional Factors — Preventive Drugs — Long-Term Counseling, Dr. Javert and Dr. Richard W. Stander—Cincinnati Room.

Vascular Surgery, Dr. Szilagyi — Ballroom;

Theoretical and Practical Considerations of Magnesium Deficiency in Man, Dr. Flink — Ohio Room.

St. Rita's of Lima Schedules Inhalation Therapy Seminar

St. Rita's Hospital, of Lima, has announced an Inhalation Therapy Seminar to be held at the hospital on Saturday, October 29. Registration opens at 8:00 a. m. with the first program beginning at 8:45 o'clock. The seminar has been approved for credit to members of the American Academy of General Practice.

Morning and afternoon sessions will be held with time to view equipment of supply houses supplying equipment in the inhalation field. A dinner to honor seminar speakers will be held at Milano's Club, beginning at 6:00 p. m.

The program has been announced as follows:

Welcome by Sister Mary Caroline, R. S. M.

Introductions by Russell L. Wiessinger, M. D., medical director, St. Rita's Hospital.

Organization and Concept of Inhalation Therapy Department, Bernard Kew, head of R. I. T. at St. Alexis Hospital, Cleveland.

Humidification and Nebulization, Harold Stevens, M. D., anesthesiologist and medical director of the Inhalation Therapy Department at Toledo Hospital.

Emphysema; Detection and Maintenance, Joseph Tomashefski, M. D., Cardio-Pulmonary Laboratory, University Hospital, Columbus.

Cardiac Emergencies and Inhalation Therapy, Michael Orlando, M. D., director of the cardiology service associated with the Cardio-Pulmonary Laboratory, Miami Valley Hospital, Dayton.

Management of the Post-Resuscitation Patient, Robert Ditmar, R. I. T., Miami Valley Hospital, Dayton.

Post-Operative Ventilation, Marion Connerley, M. D., Terre Haute, Indiana, diplomate of the American College of Surgery and the American College of Thoracic Surgery.

OSU Third Symposium on Diabetes Mellitus

Ohio State University College of Medicine and the Central Ohio Diabetes Association are jointly sponsoring the third symposium in this specialty field on Wednesday, October 26. Under the general title, "Diabetes Mellitus: Past, Present, Future," the theme of this symposium is "Vascular Disease and Diabetes."

The place is the Fort Hayes Hotel, 31 West Spring Street, in downtown Columbus. Registration opens at 8:00 a. m. with the first program feature at 9 o'clock. A $15.00 registration fee should be sent to the Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. Tenth Ave., Columbus, Ohio 43210.

The program has been announced as follows:

(Continued in Next Column)

Welcome by Dr. James V. Warren, professor of medicine and chairman of the Department of Medicine at OSU.

Tecumseh Report — The Prevalence of Abnormal Carbohydrate and Lipid Findings and Their Association with Coronary Artery Disease — Dr. Leon D. Ostrander, Jr., associate professor of internal medicine and research associate in epidemiology, University of Michigan.

Diabetes and Vascular Disease Including a General Classification with Specific Emphasis on Atheromatosis — Dr. Campbell Moses, associate professor of medicine and director of the Addison H. Gibson Laboratory, University of Pittsburgh School of Medicine.

Capillary Basement Membrane Thickening in Diabetes and the Pre-Diabetic State — Dr. Marvin D. Siperstein, professor of internal medicine, University of Texas Southwestern Medical School.

Panel Discussion, moderator, Dr. George J. Hamwi, professor of medicine and director of the Division of Endocrinology and Metabolism, OSU.

Diabetes Mellitus, Lipids, and Coronary Disease — Response to Diet — Dr. Margaret Albrink, professor of medicine, West Virginia University School of Medicine.

Diabetes Mellitus, Lipids, and Coronary Disease — Response to Pharmacological Agents — Dr. Manuel Tzagournis, instructor in medicine, OSU.

Prevention — Dr. Laurance W. Kinsell, director, Institute for Metabolic Research, Highland General Hospital, Oakland, Calif.

Panel Discussion, moderator, Dr. Thomas P. Sharkey (Dayton), clinical assistant professor of medicine, OSU.

* * *

Other postgraduate courses offered at Ohio State University in the near future include the following:

October 20 — Pediatric Invitational Clinic.

October 31 - November 23 — Board Refresher Course in Psychiatry.

November 17 — Muscular Dystrophy.

November 30 — Orthopaedic Seminar.

Details may be obtained from the Center for Continuing Medical Education, at the foregoing address.

Dr. John R. Seesholtz, Canton, a past president of the Canton Rotary Club, was guest speaker at a luncheon meeting of the Salem Rotary Club, where his topic was "Humor in the Practice of Medicine."

Physicians in State Mental Hygiene Schedule Program October 14

The Association of Physicians of the Department of Mental Hygiene and Correction of the State of Ohio will meet on October 14 at the Columbus State School, Columbus. Joining them will be the Association of Directors of Out-Patient Clinics of the Department.

Dr. Rudolph A. Buki, president, will present Dr. Judith Rettig, superintendent of Columbus State School, who will welcome the Associations. "The Community Service Unit" will be the subject of the paper of Dr. Abdon E. Villalba following which a business meeting will be held prior to lunch.

Dr. Julius Nemeth, in the afternoon, will present a paper, coauthored by Dr. M. Petrovich on "Four Years of Clinical Experience with combined Chlorpromazine and Trifluoperazine Treatment."

Guest and principal speaker will be Dr. William Grater, clinical assistant professor of allergy in the Southwestern Medical School, Dallas, Texas, who will address the session on "Common Sense in Drug Allergy."

Cleveland Clinic Foundation Announces PG Courses

The Cleveland Clinic Educational Foundation, has announced a number of postgraduate courses of interest to physicians and allied groups.

Details on these and other activities of interest may be obtained from Walter J. Zeiter, M. D., director of education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

The following courses have been announced:

October 19 — Update 1966 — Selected Topics in Nursing.

November 4 — Medical Technology.

November 16 and 17 — Diagnosis and Treatment of Neuromuscular Disorders.

December 7 and 8 — Postgraduate Course in Ophthalmology.

January 11 and 12 — Advances in Dermatology.

January 18 and 19 — Controversies in General Surgery.

February 1 and 2 — General Practice.

Dr. James Z. Scott, Scio, won his silver wings during a training tour at Volk Field, Wisconsin, this summer. He is a lieutenant commander in the Ohio Air National Guard and commander of the 121st Tactical Hospital Squadron.

Dr. W. Hugh Missildine, was principal speaker at a fellowship dinner meeting at the Boulevard United Presbyterian Church in Columbus. His topic was "The Challenge of Change in Self."



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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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The Future of General Practice

By ROBERT E. CARTER, M.D.

WITH YOUR PERMISSION, I will introduce this talk with several questions: "Why is there such concern about general practice?" "What has prompted your medical school to invite me to travel a thousand miles to talk about general practice when I am a specialist and not even in practice at the present time?" "What is your motivation in coming to hear what I have to say?"

In attending and in giving this lecture, both you and I are aware of a greater issue. We know that a complete solution is not presently available, but we realize that the issue will figure prominently in our professional futures.

For several years, general practice has been the subject of a national debate, a controversy which will continue for years to come and which involves more than the issues inherent in learning a scientific discipline. It involves the structure of a science, our method of delivering medical care to our citizens, many of our educational methods, and even some parts of medical research. I refer to the extent of specialization and the extent of generalization in medicine. The debate concerns the life or death of general practice.

How the Argument Developed

Before I present my arguments in favor of retaining a significant amount of generalization in medicine, I want to trace how the argument started, since it illustrates many parts of the problem.

At the end of the Second World War, leaders of the medical profession in this country embraced specialization as the method for delivering medical care to our population. It looked easy and correct. The problem of mastering rapidly increasing scientific knowledge was solved. The millennium of scientific biology applied to a grateful population was almost at hand, and the total specialty system promised that each of us could find an area where we might approach complete professional competence.

To justify this delightfully naive view of science and of medical practice, specialty advocates cited cases from other disciplines. Had not the physicists seemed to completely specialize, the chemists, the geologists, and everyone else? Medicine was late in catching on, they said, and pointed to preliminary evidence that total medical specialization seemed to be a successful system for delivering care in some communities.

A second factor led us to project this model of specialty practice. America went from rags to riches between 1933 and 1950. Just enough people could afford specialists, and the ratio of physicians to total population was high enough to maintain a balance between demand for service and the ability to pay for special consideration. The desperately poor went to charity institutions, and we heard it said that they got better medical care than did our richer citizens.

This was simply not true in many instances. We ignored the lessons to be learned from overworked house staffs, deteriorating hospitals, and increasing demands for better service from the indigent and the old, while we concentrated on perfecting the total specialty care system for the affluent and for medical education. I think, **most important,** we failed to realize that the total specialty system for medical care was not successfully applied at most large charity institutions. It succeeded only where large student, intern, resident, and fellowship groups existed. It was present in name only in some hospitals, or as a cumbersome and inefficient method in others.

Some Justifiable Complaints

You know the complaints as well as I do—patients treated as diseases rather than as people; interminable delays in outpatient clinics and the emergency room; incorrect utilization of emergency rooms; confusion; lack of identification, no one really responsible for a particular patient; and, questionable medical practices — the old joke about the safest place for a carcinoma of the rectum to develop unmolested being in the cardiac clinic.

These problems were apparent in our charity medical practices long before they appeared in the care of our better classes, and we chose to ignore them. Now, as the pressures of population mount, and as specialization increases, we hear them everywhere. They must be recognized for what they are, and we must be very analytical in our evaluation of the total specialty medical practice model. It has **not** performed well where the ratio of physicians to patients is low.

Let me go on to a third point which led us toward complete specialization, the influence of scientific progress on medical practice in the two decades from 1940 to 1960. Stop for a moment to think what

This is the text of Dr. Carter's discussion as Guest Lecturer in Family Medicine at the Ohio State University College of Medicine. *The Journal* is publishing this manuscript with the knowledge that it represents one side of a moot question of considerable interest to the medical profession, and with the observation that Dr. Carter's presence demonstrates willingness on the part of a leading medical school to consider the problems involved. Dr. Carter is assistant dean, State University of Iowa College of Medicine.

happened when we combined effective antibiotics, diuretics, and psychotherapeutic drugs. Medical practice seemed invincible. We kept abreast of our expanding population and increasing demand for service through an actual increase in therapeutic efficiency, through a remarkable and possibly quite singular combination of scientific discoveries.

But there has not been a penicillin for 25 years, nor a chlorothiazide for 15, or a chlorpromazine for 10, and I am sure none of us wish to gamble on a future, as yet unknown, scientific discovery to pull us out of a current social dilemma until we have explored and been forced to discard more realistic alternate solutions.

The Extension of a Model

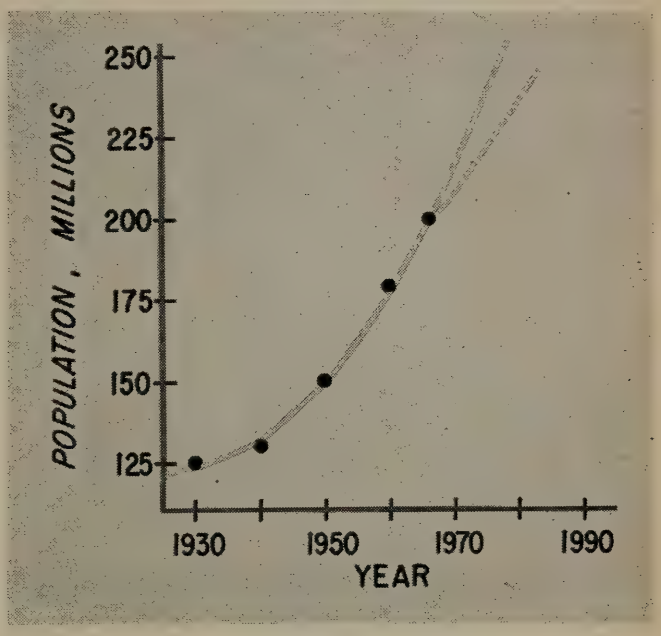
But before we indulge in too much retrospection, let's add up the picture in 1950 as it was viewed then. Combine affluence, remarkable scientific advance, and increased therapeutic effectiveness, and it is not hard to see how people were encouraged to make the last bold step, the extension of a model to the universal state. In effect, the decision was made that each of us would eventually specialize in some branch of medicine. Specialty residency positions were increased to a total of 39,000 - 7,000 more than the total number of medical students enrolled in all four years of all medical schools in this country. Specialty boards multiplied faster than legitimate disciplines could be identified, and we began to speak of gerontologists, abdominal surgeons, and pediatric allergists. The number of physicians entering general practice declined precipitously!

There are many indications that we must examine the concept of total specialty practice more closely, for the contradictions and inconsistencies which seemed insignificant at first have assumed greater importance as time goes by. This is typical of any scientific theory. They represent extensions of preliminary information to fit all circumstances. At first, such generalizations seem logical. The exceptions, the few facts which don't fit the theory are either ignored or are considered to be bad observations and poor data. The theory isn't wrong according to its proponents — the facts are! But, eventually, the inconsistencies increase in number until the theory comes tumbling down. A new one must be created to take its place, a fresh model which more accurately describes reality. It happened to the older theories of gravity, of relativity, and of parity, and it will happen to the concept of total medical specialty practice as surely as you and I are in Columbus, Ohio, this afternoon.

Flaws in the Model

The flaws in the total specialty model can be listed very simply. First, no other scientific discipline has ever approached total specialization in the context that it was proposed for medicine. Second, total specialization with its attendant isolated knowledge in depth may apply uncommon information to common occurrences, information which may not actually pertain, a fact escaping the intellectually isolated scientist. Finally, integration of knowledge shares equal importance with the discovery of new information. It is a different type of synthesis, but without such correlation, segments of knowledge disperse on hopelessly separate courses.

Until now, the debate on generalization and specialization has been argued on scientific principles



SLIDE 1

alone. General practice has been eclipsed because our attention was focused only on the "impossibly large amount of information to be mastered." We succumbed to the convenience of a system which said, "Stay here, isolate yourself, learn only this and treat what you choose." In recognizing the contribution that specialization makes to progress in any scientific discipline, we ignored the correlary requirement, breadth of knowledge.

Let me make it perfectly clear at this point that I recognize the rapid increase in total medical knowledge and that I recognize the advantages which can accrue from intensive study in isolated areas. My argument is not to return to total generalization but to halt the current progress toward total specialization. It is scientifically essential that we retain a proper ratio between generalism and specialism in medicine.

But, there are events outside the scientific realm which will also decide our future and which will force us to retain a significant number of generalists in our total force of physicians. The first is the rapid growth of the population, the second is our inability to train enough new physicians.

You are aware of the population growth. In the first slide (see illustration — Slide 1), I have taken

available data from the last four national censuses and from the quite accurate estimate of the present United States population. The message in this graphic is crystal clear. The only argument at the present time is a relatively narrow range in the rate of growth and its effects for the next ten years. Optimistic predictions indicate a population of approximately 220 million by 1975. Pessimistic predictions indicate about 240 million. Numerous factors enter into calculation of the ranges in these predictions, and we are aware that a small change in our fertility could cause a quite large absolute population change, albeit a small relative figure at our present level of abundance.

Now, let's take a quick look at the effect which this population growth has had on statements of principle from our total specialty practice advocates and their remarkable change over the past 15 years. Take, for example, the obstetricians (see illustration — Slide 2) — or the pediatricians (Slide 3) — or even the internal medical specialists (Slide 4) —.

Cracks in the Fortress

I think it is apparent that cracks are beginning to appear in the walls of the specialists' fortress. The image does not seem as attractive as it was at one time. And, look at the solutions! Perhaps there are answers other than midwives and technicians and the host of paramedical personnel which are now projected as both dispensers of medical care and as diagnostic assistants. I hope so, because the history of problems of this type indicates that the master-servant relationship is difficult to maintain.

I will return to this point in a moment, but, next, let's consider the second variable — the rate at which we are able to produce new physicians. The present ratio of physicians to total population is shown in the next slide (Slide 5). I especially like this one because it presents both sides of the argument, the optimistic view in the top curve, also known as the American Medical Association position, and the pessimistic outlook at the bottom, possibly identified with the Association of American Medical Colleges. The top curve is the ratio of total physicians to population and it is constant and has continued to be constant to the present time. It includes all physicians who are alive, every one that's breathing, and it is dependent on a high input of foreign graduates. The lower curve are people actually treating the sick, and, as you can see, it is falling steadily and has continued to fall since this curve was made in 1964.

If we are to maintain the ratio indicated in the top curve, it will be necessary to continue the high input of foreign physicians into the permanent American talent pool. It will be necessary to increase the number of American graduates from our present 8,000 to 11,000 by 1975, and considering inevitable attrition, this means 4,000 new freshman positions by 1971. Present schools would have to increase their enrollment by nearly 20 per cent by 1971, and we would have to matriculate nearly 2,000 freshmen in brand new medical schools by 1971, schools which really do not exist in 1966.

This will be a neat trick, and all it will accomplish is the maintenance of the ratio in the top curve of the slide just projected (Slide 5). It may have no effect on the decline in the lower curve for some years after 1975. Can we accomplish these goals? I personally doubt it very much at the present time. Monies made available by federal and state sources for expansion and new construction are not equal to the task, and every indication is that significant inflation will reduce both the actual and relative amounts of federal money available to medical schools.

How Many Treating Patients?

Let me spend another minute on the difference between the total number of physicians and effective physicians. An increasing number of persons holding the M. D. degree will be diverted into positions where they do not treat patients. They are essential in these jobs, and since this drain cannot be stopped, we must look at the efficiency of the physicians still treating our population. We have already alluded to increased efficiency of care resulting from singular scientific discoveries from 1940 to 1955.

Has the trend toward specialization also resulted in any increase in efficiency for the individual specialist? Here the answer is not as apparent and very little data actually exist. It seems obvious that increased skill in diagnosis and increased total knowledge will result in better patient care, but it is equally apparent that effective care to large numbers of persons may actually suffer with increased specialization of each physician. Perhaps I can illustrate this a little more clearly in the next slide (Slide 6). As a physician's depth of knowledge in a specialty area increases, and as he limits himself to these increasingly esoteric pursuits, there are a smaller number of the total population to whom this knowledge applies. A simple analogy is the physician who, upon completing his internship, takes a residency in ophthalmology and later limits his practice to the highly rewarding and interesting treatment of retinal detachment. The contribution to the care of the total population goes through a very predictable change. His medical usefulness, as measured by the highest quality of care given to the greatest number of people, increases to a maximum and **then decreases again.**

The figures on this graphic are relative, of course. It is schematic but it does illustrate where we are with much of our thinking about specialization and generalization in medicine. Beset with ever increasing numbers of persons to be treated, with a possible limit on the number of physicians we can train, and with an ever increasing body of total scientific knowledge, we must actively seek that combination of events which will give us the greatest amounts of everything we want, the most people treated with

1950 *150 MILLION PEOPLE*

Let the certified Obstetrician deliver the infants.

Close the hospital staff !



1965 *200 MILLION PEOPLE*

We must train midwives again !

There will never be enough Obstetrician !



SLIDE 2

1950 *150 MILLION PEOPLE*

Pediatricians will be the general practitioners

for our little folks !



1965 *200 MILLION PEOPLE*

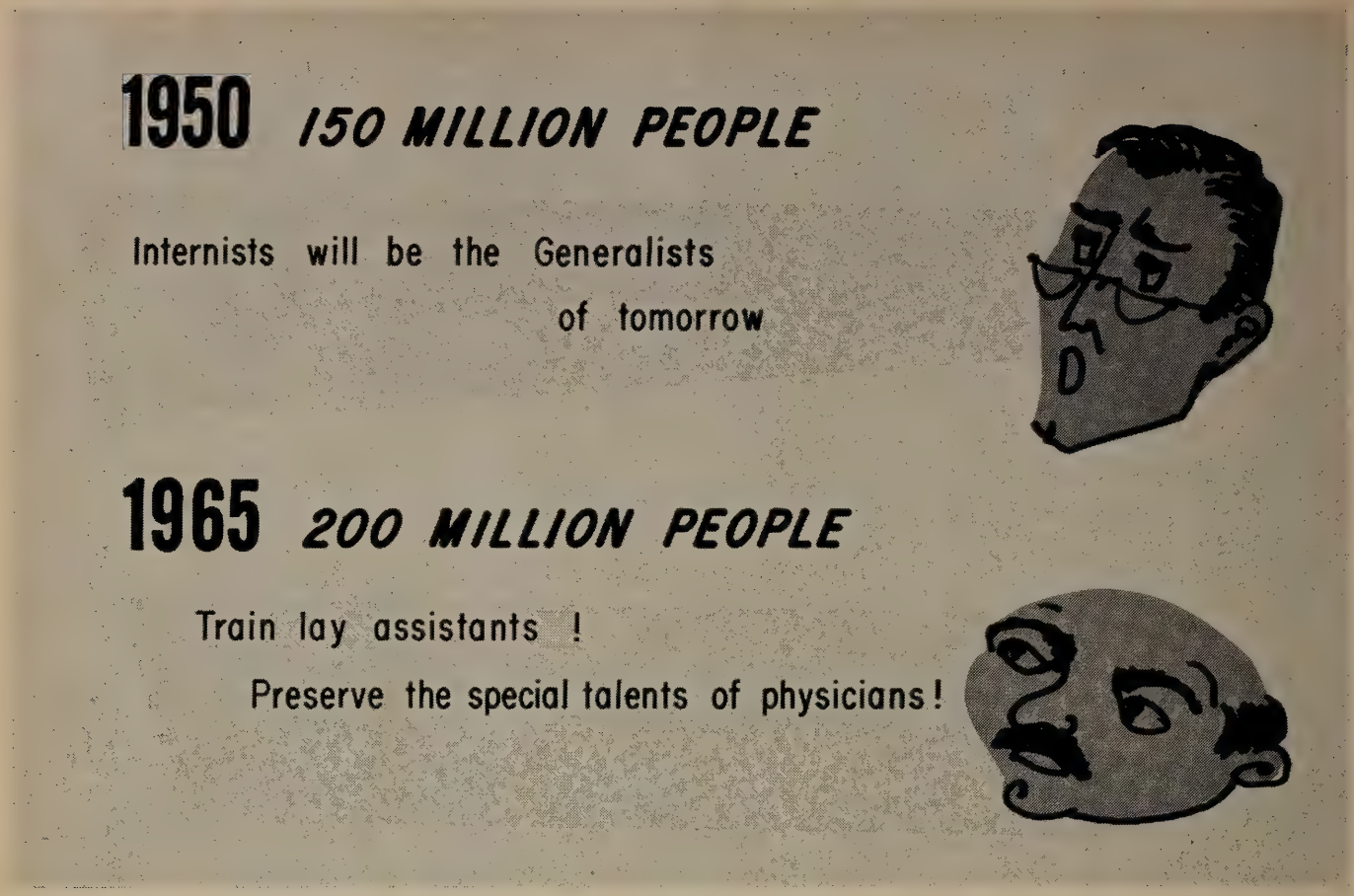
If you want a Pediatrician for every child,

all medical school graduates for the next five years

must become Pediatricians ! *Preposterous !*



SLIDE 3



SLIDE 4

the most sophisticated form of our science, and the most rapid progress toward new information. Maximum in these situations does not mean all of everything. It means as much of each desirable as we can afford.

Recapitulation

Before I suggest a solution for your consideration, let me briefly recapitulate the points I have attempted to make. **First,** our population will increase at a rapid rate despite all reasonable attempts to control its growth. **Second,** to maintain present ratios of physicians to total population, we will have to produce a sharply increased number of graduates. It does not seem likely at this time that we can achieve this goal. **Third,** while a portion of our shortage can be corrected by importing foreign graduates, we must be aware of the world-wide effect of this course of action. The United States is the world leader in science and medicine. We should export physicians rather than import them. Developing nations realize this more than we do. **Fourth,** while increased medical **knowledge** may increase the efficiency of individual physicians, the very act of intensive specialization may reduce a physician's effectiveness in meeting the total needs of the population. **Fifth,** our present experience with the model of total specialization as a method of delivering medical care to our population is not encouraging. **Finally,** no other science has specialized to the extent that we appear to be heading in medicine.

Significant Alternatives

What, then, is to be the solution? Only two significant alternatives have been suggested. The first is the suggestion of some that we create a large number of paramedical personnel, people who will actually provide first-contact care for much of the population. They will be the nurses, the technicians, probably even social workers, possibly even the pharmacists. They will screen and, in effect, treat many common ills. They will diagnose, and conduct therapeutic trials.

Let's not deceive ourselves, it is happening more and more today, with office nurses and with many others. While the majority of these persons at present operate under quite close supervision, and with instant recourse to the consultation of a physician, future plans suggest that they will be much more independent. I am not referring to the admonition on the TV screen that if a headache persists, you should see a physician. I am suggesting that these individuals will give both first contact triage and occasional continuing supervision in many cases. This will leave the physician free to devote his attention to only those cases needing advanced skills. It postulates that there will be continued increased specialization. In essence, it creates two levels of medical care and two levels of medical practitioners.

Don't be fooled for a minute about this. No matter what we call him, the health technician will function as a physician and will eventually demand and

receive both from us and from society the recognition as a physician. **Such a two level system can work, but only when there is a common base of instruction.** This is what other scientific disciplines do, and it is what we did in medicine successfully for a number of years with generalization and specialization.

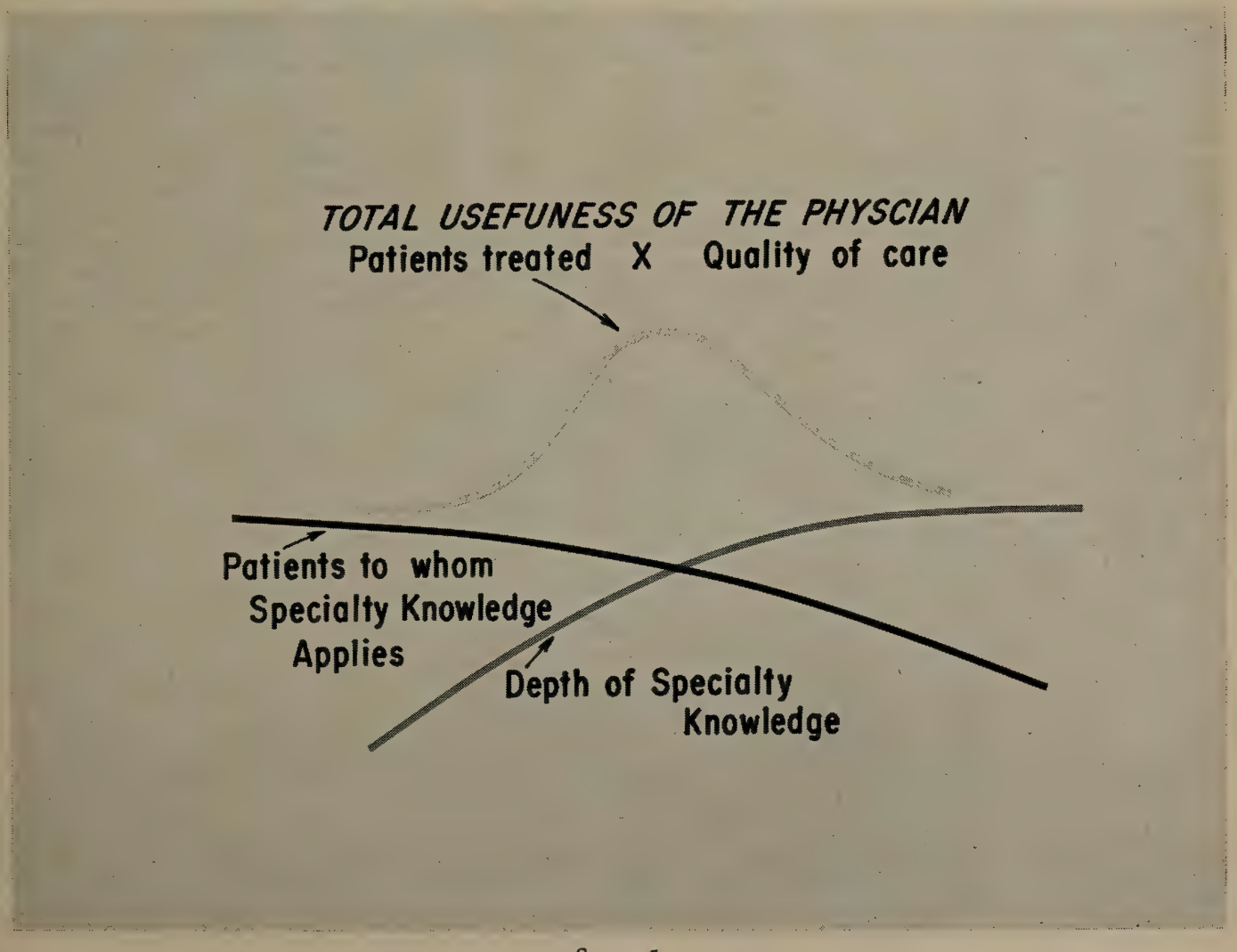
The system is under stress now partly as the result of the forces which I listed earlier, and partly because of our inability to maintain a sufficiently large supply of physicians. A two-level system based on different levels of basic training will not be successful and will eventually convert to one basic level of instruction. This is what is happening with osteopathy and conventional medicine today.

Second Alternative

The second solution to our problem is the intentional retention of general physicians and the training of these physicians to meet the needs of the majority of our population. By no means do I mean that specialization should be eliminated, but we must keep physicians with a broad viewpoint and hence a singular diagnostic ability, physicians competent in several areas of medicine and performing in these areas to the limit of their ability. These are the correlators of medical information identified by Magraw, and they are much **more** — they are active therapists.

At this point we must answer a specific question. You hear repeatedly that there is too much to learn to be a general practitioner. Most of this comment comes from our medical educators. Is it really true, or does it represent a viewpoint influenced by a singular patient population and demands not encountered in private practice?

An unhealthy influence has pervaded a number of medical schools and has resulted in an oddly biased view of the practice of medicine. This suspicion is not original with me; it has been identified by others in academic pursuits. They can show that only one patient in 700 ever is treated in a University Hospital, and that the total of these singular patients represent a profile of disease unrelated to any in private practice and probably unsuited for undergraduate training. The internist, the surgeon, or the pediatrician functioning in such an atmosphere must view medical practice as a series of complexities requiring tremendous depth of knowledge, and a necessary constriction of interest. Since medical students receive the majority of their instruction from such faculty and from such patient material, how can they do otherwise



SLIDE 5

than assume that comparable cases may appear in their office day after day.

The Commonplace and the Rare

The fact is, of course, that they do not. Most patients have diseases which are adequately treated by physicians with sound basic training and who retain interest in many facets of medicine. Morbidity studies bear this out and support what you already know intuitively: rare diseases are rare. It is both unnecessary and impossible to train a generalist to care for these complexities. But you ask: can such patients be identified and directed to proper care? Isn't there a danger of missing them for too long? Adequate generalists can both treat the commonplace and refer the unusual when necessary. This system has worked in the past. Despite what many students may hear in school, the majority of physicians practice excellent medicine. The reasons rare cases are in University Hospitals is that private practitioners have sent them there.

But, you say today is really different. Now there really is too much to learn for even a core. People have always felt this. I would like to refer to a speech by a famous medical educator from the Harvard Medical School in March.[1] He said, "In modern times, the constituent advances of medical science are so expanded that they are not to be acquired by any physician in a lifetime and still less by any student in his pupilage." The only trouble is that this was not said by Dr. Ebert but by Dr. Jacob Bigelow, and the year was 1850, not 1966. In 1850 this statement was as true as it is today, but it still does not preclude the intentional identification and mastery of those core facets of medicine which will be of such service to all of mankind.

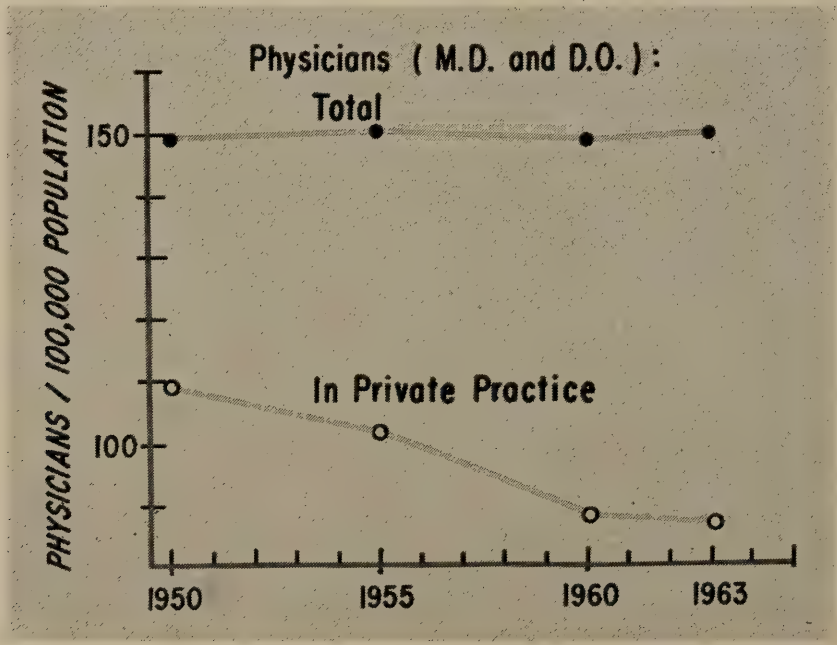
Let's consider one additional point. Nearly every person receives his medical care from a physician in private practice, or will very shortly. The majority receive it in a physician's office rather than in a hospital emergency room or clinic. The majority still receive their care from physicians whom they identify as their doctor, and we must not forget this essential ingredient in the physician-patient relationship. When the patient first comes to his physician with a complaint, he views that doctor in a singular way. To the patient, he embodies the sum of medical knowledge, a person who can either apply a portion of this knowledge or find someone who can. As diagnostic steps in this initial evaluation proceed, the point is reached where the patient may accept a referral, if necessary, but only for a particular area or problem, always something less than his total self.

Let me answer a common statement today. Why can't specialists also do some general practice? We know some can and do, quite successfully. But I am concerned about several things for the majority: the complacency of certified success, the lack of **constant** need to know in areas other than their own, lack of complete identification with many patients. As a solution to our present problem, recommended by some in the form of increasing internists and pediatricians and having every other specialist do a little general work on the side, it falls short of a logical goal.

A Look to the Future

What then is the future of general practice in this country? I think that no matter what our point of view, it is very promising indeed. It is desirable to retain general practice if we are to provide really adequate, integrated medical care for the majority of people. General practitioners must be good enough to be supported by specialists, and we must have specialists good enough to support them. They must be produced in adequate numbers so that they

(Continued on page 1068)



From Pennell, M. Y.: Statistics on Physicians, 1950-63, *Public Health Reports*, 79:905, 1964

SLIDE 6

ior tension headach

Dialog™
(allobarbital and acetaminophen CIBA)

Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

For your convenience—prescription-size bottle of 30.

CIBA Pharmaceutical Company, Summit, N.J.

CIBA

(Continued from page 1064)

have enough time to appreciate their patients and their patients can appreciate them. They must treat the majority of disease and supply patients to a sophisticated specialist superstructure. We must produce a sharply increased number of physicians of many types in this country, but principally generalists.

If total physician production must be less than optimum, all the more reason for concentrating on the product who can most efficiently meet the needs of most people. The alternative is an array of health technicians and a hopelessly fragmented specialty practice.

Retention of general practice is inevitable if we are to provide the medical care we want for our burgeoning population.

Not let's consider our general practitioner in a little more detail. Will he be a family medicine man? Of course — he will need the public health, psychological, and sociological information to correlate and apply medical data. But this alone is not enough, it is **not** the total body of knowledge singular to family practice. It could be common to any specialty. Our general practitioner will need **as well** a constantly updated core of medical information which applies to the majority of human ills. And he will need to keep his wits sharp by facing multiple challenge.

Should he be trained after medical school? Both you and I know he should — for two or even three years in key medical, pediatric, and psychiatric areas. He should have latitude for individual interest and expression.

Will he **do** surgery? Occasionally. Not the big operations but certainly some less complicated ones. But what about the surgeon's view that every operation is potentially a major one? Come on now — this is just not true! If a first year surgical resident can do an appendectomy with as little supervision as so many get, so can a conscientious and trained generalist. Let's be honest!! I could go on down a rather long list!

Should a generalist deliver a baby? If a midwife can, so can he, with comparable training.

If we **must** have general practice, then who will be these generalists? Which students? You or the fellow next to you? Or, should we leave it for the chap at the bottom of the class?

We need the top half of the students in this room — the students smart enough, secure enough, and sufficiently dedicated to the principles of medicine that they will both accept and meet a genuine challenge. We need good enough personality structures to be comfortable with less than complete knowledge and to concentrate on **necessary** knowledge. We need physicians whose reward is meeting the genuine needs of others, not written certificates of success. We need the best of you to practice superior medicine on as many people as you can.

Those of you who cannot accept such challenges or aspire to these goals **should** specialize.

Reference

1. Ratner, Herbert: Deficiences in Present-Day Medical Education. *GP*, 32:185-188 (July) 1965.

American Academy of Pediatrics Features Ohioans on Program

A number of Ohioans are on the 35th Annual Meeting Program of the American Academy of Pediatrics, scheduled in Chicago, October 22-27. Headquarters hotel is the Palmer House.

Dr. Thomas E. Shaffer, Columbus, will participate in a panel discussion on the subject, "Athletics for the Growing Child."

Dr. Sylvia Richardson, Cincinnati, will present a round table discussion on "School Readiness."

Dr. Lester W. Martin, Cincinnati, will present the second of two round table discussions on "Visual Diagnosis."

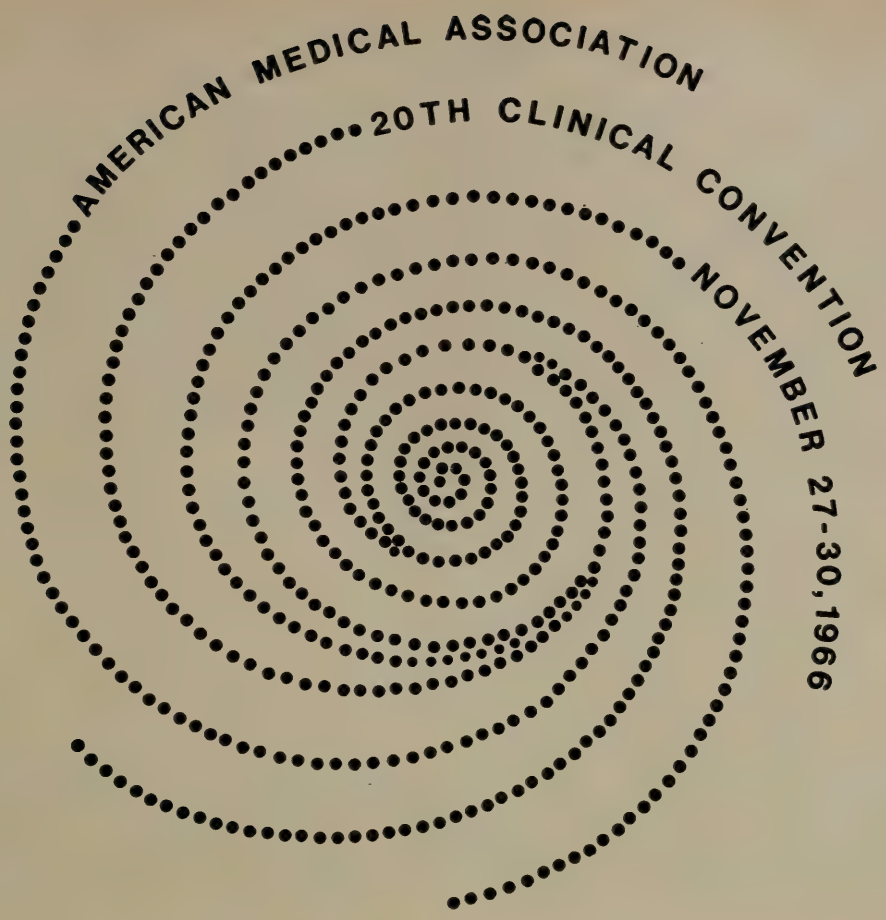
Dr. Lester Persky, Cleveland, will tell about "Experiences with Childhood Vesical Tumors," in a panel discussion on "Urinary Tract Infections in Children." He also was moderator of a panel on "Scrotal Masses in Children."

Dr. John P. Smith, Columbus, will discuss "Testicular Tumors in Children," during a panel presentation on the subject, "Scrotal Masses in Children."

Among alumni meetings are luncheons scheduled by Children's Hospital of Columbus (Ohio State University College of Medicine), Western Reserve University and Allied Hospitals Alumni, and Cincinnati Children's Hospital Alumni. A reception is scheduled by Akron Children's Hospital Alumni Association.

Executive officers of the American Academy of Pediatrics are at 1801 Hinman Ave., Evanston, Illinois 60204.

As to the evaluation of medicines for efficacy and safety, the computer is not the final and perfect answer, useful though it is. What the physician feels and perceives at the bedside of his patient may not fit into the square, or oblong or round hole of the punch card; but his observations are often a surer guide to the usefulness of a particular medicament for a particular patient. In the interest of the patient—that individual is so unique that there is not another entirely like him in the whole wide world — we must be careful lest the scientific pendulum swing too far in the direction of mechanistic technology. — J. Mark Hiebert, M. D., to University of Kansas Pharmacy Colloquium.



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Three Postgraduate Courses will be presented: Obstetrics and Gynecology • Fluid and Electrolyte Balance • Cardiovascular Disease. Each Course will consist of three half-day sessions, and there will be a registration fee of $10.00 for each course, payable with your advance registration.

Four Breakfast Round Table Conferences will be held on the following topics: The Management of Metabolic Bone Disease • Indication for Cardioversion • The Problems and Potential of L.S.D. • An Agonizing Reappraisal of Cancer Chemotherapy • **Closed Circuit Television • Medical Motion Picture Programs • Over 275 Scientific and Industrial Exhibits.**

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 24.

Outstanding Scientific Exhibits At the OSMA Annual Meeting

OUTSTANDING FEATURE at the 1966 OSMA Annual Meeting in Cleveland, May 24-28, was the Scientific and Health Education Exhibit. In keeping with a policy recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for certain exhibits designated as outstanding by the judging committee. This year seven exhibits were selected to receive the special honors which included mounted and engraved plaques, certificates and monetary awards. The committee designated three exhibits in the field of teaching, and three in the field of original investigation to receive respectively the gold, silver and bronze awards, and named a seventh exhibit to receive a special award. Following are brief descriptions of two of these award-winning exhibits.

Gold Award Goes to Exhibit on Circulation in Bone Repair

The Gold Award in the field of Original Investigation was presented at the 1966 OSMA Annual Meeting to sponsors of the exhibit entitled "Stereoscopic Microangiography: Observations on the Microcirculation in Bone Repair." Sponsors were Dr. F. W. Rhinelander, Dr. R. S. Phillips, and Dr. W. M. Steel, Western Reserve University School of Medicine and Cleveland Metropolitan General Hospital, Cleveland.

Principal investigator in the research presented by the exhibit is Dr. Rhinelander who is professor of orthopaedic surgery and chief of the Orthopaedic Service, Cleveland Metropolitan General Hospital. The work presented in the exhibit covered some of the aspects of the studies being carried out in the local laboratory on the microcirculation of healing bone.

Two articles on this investigation have appeared in the literature. "Microangiography in Bone Healing; Undisplaced Closed Fractures," appeared in *The Journal of Bone and Joint Surgery,* 44-A, 1273-1298, October 1962. "Some Aspects of the Microcirculation of Healing Bone," appeared in *Clinical Orthopaedics,* #40, 12-16, 1965. An article on "Displaced Closed Fractures" is in press. Reports of the investigation on internal fixation of bone and on bone grafts are in preparation.

A resume of points covered in the exhibit was published in the Proceedings of the American Academy of Orthopaedic Surgeons, Scientific Exhibits, in the issue of *The Journal of Bone and Joint Surgery,* July 1964, 46-A, 1151-1152.

The reason for preparation of this particular scientific exhibit was to demonstrate the microangiograms in stereoscopic viewers. Three dimensional views are much more striking where the blood supply of fractures and bone grafts is concerned, compared with the flat illustrations in published articles.

All of the work portrayed has been supported by a National Institutes of Health research grant, which has recently been renewed for an additional five years. The sponsors point out that the studies of healing bone are far from complete.

Different panels of the exhibit illustrated selected experiments from various studies on dogs. Microangiograms revealed in detail the complex arteriolar and capillary vascular pattern present in one-millimeter-thick slices of bone and periosteal tissue.

Illustrations showed (1) normal blood supply of the long bones; and circulation and bone repair of (2) undisplaced closed fracture in which the main medullary artery was not disrupted at fracture; (3) displaced closed fracture in which the medullary blood supply was disrupted; (4) transverse osteotomy and fixation with medullary rod; (5) transverse osteotomy and fixation with Lane plate and screws; (6) transverse osteotomy and fixation with angle plate and wires; and (7) vascularization of the grafted area in a bone graft with autogenous cancellous chips.

Exhibit on the Geriatric Patient Is Winner of Bronze Award

The exhibit entitled "Office Evaluation of the Geriatric Patient," sponsored by a team from the Ohio Department of Health and the U. S. Public Health Service Gerontology Branch, won the Bronze Award in the field of Teaching at the 1966 OSMA Annual Meeting.

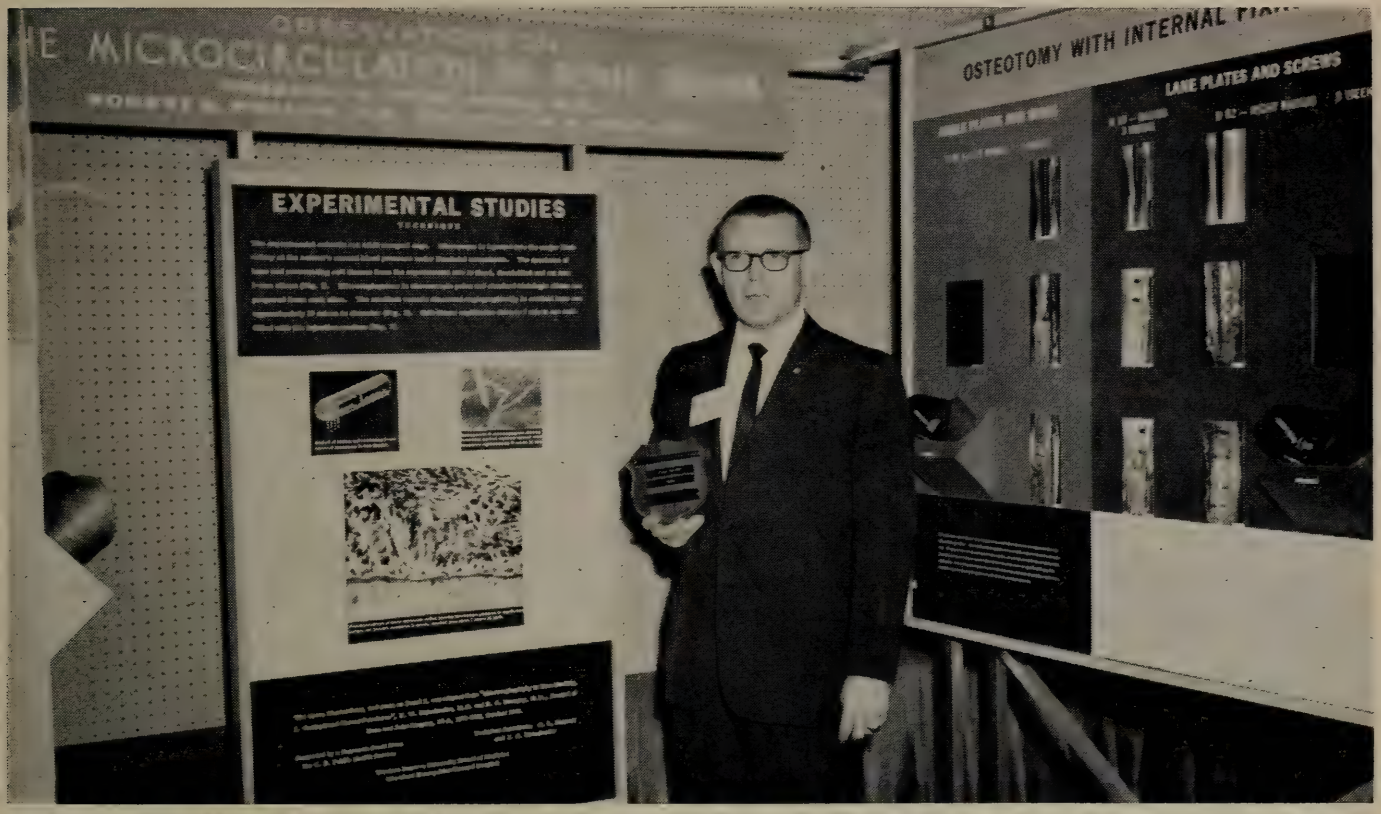
Among individuals who participated in preparation and presentation of the exhibit were Dr. Emmett W. Arnold, director of the Ohio Department of Health, Dr. Aileen L. MacKenzie, Frances Williamson, Richard W. Orzechowski, and Dennis Webb.

The exhibit was developed by Dr. Austin B. Chinn, Gerontology Branch, Division of Chronic Diseases, U. S. Public Health Service. It was a large display which included a screen for the presentation of color slides and an accompanying narration. Audience participation was encouraged by means of a push-button device and earphones for listening.

The presentation dealt with the basic requirements

(Text Continued on Page 1072)

Views of Award Winning Exhibits



This is the Gold Award winning exhibit in the field of Original Investigation entitled "Stereoscopic Microangiography: Observations on the Microcirculation in Bone Repair," as it was shown at the 1966 OSMA Annual Meeting. Placing the Gold Award plaque on the exhibit is Dr. Lawrence C. Meredith, OSMA President. (See facing page for additional information.)



Dr. Eleanor Smith, of the U. S. Public Health Service Gerontology Branch in Washington, is shown holding the Bronze Award in the Teaching Field, presented to sponsors of the exhibit entitled "Office Evaluation of the Aging Patient." The exhibit was jointly sponsored by the Ohio Department of Health and the Gerontology Branch of USPHS.

(Outstanding Exhibits Contd.)

for an annual physical examination of the geriatric patient by the private physician in his office. On either side of the exhibit were panels with built in desks, chairs and literature racks with pertinent material displayed and order blanks available.

Available publications were widely varied in scope and included the Cornell Medical Index Health Questionnaire by Keeve Brodman, M. D., Albert J. Erdman, Jr., M. D., Harold G. Wolff, M. D.; Automated Multiphasic Screening and Diagnosis by Morris F. Collen, M. D., BEF, Leonard Rubin, M. D., Ph. D., Jerzy Neyman, Ph. D., George B. Cantzig, Ph. D., Robert M. Bair, Ph. D., A. B. Siegelaub, M. S.; Geriatric Nutrition by Geraldine M. Piper and Emily M. Smith.

Dr. Arnold reported that there were many requests for literature besides the literature available at the exhibit.

The exhibit portrayed the opportunities open to the practicing physician for total health care of the aged patient. It pointed out that if there is any single characteristic about illnesses in older people, it is their multiplicity and interrelatedness.

Additional requests for literature on this subject or for information in regard to the geriatric patient may be addressed to the Ohio Department of Health, P. O. Box 118, Columbus, Ohio 43216.

In addition to local persons who manned the exhibit, was Dr. Eleanor Smith, now associated with the Gerontology Branch of the U. S. Public Health Service in Washington, and formerly attached to the Ohio Department of Health.

Cleveland Pathologist Shares First of Stouffer Awards

Dr. Harry Goldblatt, well-known pathologist of Cleveland, is one of two physicians to share the first annual $50,000 Stouffer Prize, for his pioneer research in the field of hypertension and hardening of the arteries. The other recipient is Dr. Ernst Klenk, of the University of Cologne, Germany.

Dr. Goldblatt is emeritus professor of experimental pathology at Western Reserve University School of Medicine, and director of the Louis D. Beaumont Memorial Research Laboratories, Mount Sinai Hospital, Cleveland.

Announcement was made by Dr. Irvine H. Page, Cleveland, chairman of the Stouffer Prize Committee. The award was established by Vernon Stouffer, head of the chain of restaurants which bear his name.

The Stouffer Prize, established earlier this year, was founded to help track down the cause, prevention or treatment of high blood pressure and hardening of the arteries.

Dr. L. Harold Martin, Ashland, an alumnus of Ashland College, has been named to the college Board of Trustees.

12 Hospitals Designated in Ohio As Needed for TB Patients

Dr. Emmett W. Arnold, director of the Ohio Department of Health, recently announced the designation of 12 tuberculosis hospitals in the state as needed to provide sufficient beds for all persons requiring hospitalization for the maintenance, care, and treatment of tuberculosis.

This action was taken in accordance with a new law passed by the 106th General Assembly last year, which also provides that the state subsidy to assist counties in the hospitalization of tuberculosis patients shall be raised from $2.50 a day to $5 a day, effective October 1, 1966.

The increased subsidy, under the new law, may be paid only for patients placed in the designated hospitals. After October, there will be no state subsidy for tuberculosis patients in non-designated hospitals.

The designated hospitals are: Benjamin Franklin Hospital, Columbus; Dunham Hospital of Hamilton County, Cincinnati; Edwin Shaw Sanatorium, Akron; Lowman Pavilion, Cleveland Metropolitan General Hospital, Cleveland; Sunny Acres, Cuyahoga County Tuberculosis Hospital, Cleveland; Mahoning Tuberculosis Sanatorium, Youngstown; Molly Stark Hospital, Canton; Ottawa Valley Hospital, Lima; Stillwater Sanatorium, Dayton; William Roche Memorial Hospital, Toledo; Ohio Tuberculosis Hospital, Columbus; Southeast Ohio Tuberculosis Hospital, Nelsonville.

Those hospitals not included are: Pleasant View Sanatorium, Amherst; Mount Logan Hospital, Chillicothe; St. Francis of Oak Ridge, Green Springs; Edwin H. Hughes Memorial Hospital, Hamilton; Richland Hospital, Mansfield; Rocky Glen Sanatorium, McConnelsville; Licking County Tuberculosis Sanatorium, Newark; and Trumbull County Sanatorium, Warren.

A nine member advisory board named by the governor last April assisted in the designation of the needed hospitals. This board met several times and submitted recommendations to the Director of Health, who is authorized under the law to make the decision on designations after giving due consideration to the recommendations.

Commenting on the designations, Dr. Arnold said the 12 hospitals will supply 1,948 beds. Recently, the average number of hospitalized tuberculosis patients in Ohio has been 1,400.

Dr. Harvey C. Knowles, Jr., of Cincinnati, was named president-elect of the American Diabetes Association at the organization's 26th annual meeting in Chicago. Dr. George J. Hamwi, Columbus, was re-elected treasurer.

Statement of Ownership, Management and Circulation

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

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7. Owner: The Ohio State Medical Association, 17 South High St,. Suite 500, Columbus, Ohio 43215, a non-profit corporation with no stock outstanding.

8. Known bondholders, mortgagees, and other security holders owning 1 percent or more of total amount of bonds, mortgages, or other securities: None

9. Paragraphs 7 and 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10. This item must be completed for all publications except those which do not carry advertising other than the publisher's own and which are named in sections 132.231, 132.232, and 132.233, Postal Manual (Sections 4355a, 4355b, and 4356 of Title 39, United States Code)

I certify that the statements made by me above are correct and complete.

R. Gordon Moore, Executive Business Manager.

New Executive Secretary Is Named For State Board of Pharmacy

The State Board of Pharmacy has announced the appointment of Frank E. Kunkel, of Cincinnati, as executive secretary to replace Dr. Rupert Salisbury effective September 1.

Mr. Kunkel has completed two five-year terms as a member of the Board of Pharmacy, his last term ending in March, 1966.

Mr. Kunkel was a Pharmacist in the Geisler Pharmacy from 1931 to 1932, and in the Benet Pharmacy from 1932 to 1937. He was a professional representative for Eli Lilly & Company from 1937 to 1940. He has been the owner of the Kunkel Apothecary since 1941. He is also a hospital pharmacist at Our Lady of Mercy Hospital, a position he has held since 1950.

SYMPOSIUM ON ADOLESCENCE

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supported by a National Institute of Mental Health Grant

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Irvin Kraft, M. D., Professor of Child Psychiatry at Baylor Medical School, Houston, Tex.

John Schimel, M. D., Associate Director of William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, New York, N. Y.

George Tarjan, M. D., Professor of Psychiatry and Program Director of Mental Retardation Project at University of California in Los Angeles, Calif.

Carroll Witten, M. D., President-Elect of American Academy of General Practice, Louisville, Ky.

Symposium will be held at the Fontainebleau Motor Hotel, 4040 Tulane Ave. Early hotel reservations are recommended.

AMONG TOPICS TO BE DISCUSSED:

"The Physician's Role in Mental Retardation"
"Parents of Problem Children"
"Handling of Adolescents by General Practitioners"
"Sexual Morality — A College Dilemma"
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Enclosed is my registration fee of $20 for the SYMPOSIUM ON ADOLESCENCE to be given December 1-3, 1966 at the Fontainebleau Motor Hotel. (Checks should be made payable to Touro Infirmary.)

Name.....

Address.....

.....

Executives of Ohio's Medical Societies Attend Second Chicago Conference

FOR THE SECOND CONSECUTIVE YEAR, executive secretaries of County Medical Societies in Ohio and the Executive Staff of the Ohio State Medical Association, met in Chicago with personnel of the American Medical Association to develop better understanding of the medical organization field and to promote better working relationships among medical groups on the national, state, and county levels.

Seventeen persons from the executive staffs of County Medical Societies in Ohio, and four members of the OSMA Executive Staff, were present at the August 23 meeting in the Board Room of the American Medical Association headquarters office.

Dr. Lawrence C. Meredith, Elyria, President of the Ohio State Medical Association, accompanied the Ohio group to Chicago and participated in discussions. The conference was sponsored by the OSMA and part of the expenses of county medical society executives were paid by the Association. Persons attending the Ohio conference also attended the Medical Society Executives' Association Eighth Annual Institute, held on August 24, and the AMA Public Relations Institute held on August 25 and 26, both in Chicago.

Closer Ties for Executives

Following the first such meeting in Chicago last year, members of the executive staffs of Ohio County Medical Societies voted to form a more closely knit organization. At a subsequent meeting in Columbus on February 26, the Association of County Medical Executives (ACME) was organized. Elected officers are Edward F. Willenborg, executive secretary of the Academy of Medicine of Cincinnati, president; W. "Bill" Webb, executive secretary of the Academy of Medicine of Columbus, vice-president; and Sidney Mountcastle, executive secretary of the Summit County Medical Society, secretary-treasurer.

Executive staff members of County Medical Societies have been meeting for many years informally with the executive staff of the Ohio State Medical Association for discussion of matters of common interest. Formation of the organization is to promote closer working relationships between executive staffs on the county and state levels and to establish more definite goals for future consideration.

At the Chicago conference, Dr. F. J. L. Blasingame, Executive Vice-President of the AMA, held an informal discussion on new developments in the medical organization field.

William C. Stronach, executive director of the American College of Radiology, spoke about the much-discussed direct billing procedure.

Oliver J. Neibel, Jr., executive director of the College of American Pathologists, discussed the relationships that pathologists and certain other physicians are facing in regard to policies of practice.

Dave Powers, administrative assistant, associated with the American Medical Political Action Committee, discussed the actions of AMPAC and those of related political action committees on the state level.

Bill Ramsey, assistant director of the AMA Field Service Division, described the functions of the field service.

Ohioans in Attendance

Attending the Conference of Ohio Executives in Chicago were the following persons:

J. H. Austin, Stark County; A. Dana Whipple, Medina County; Mrs. Patsy Jo Askins, Sandusky County; Robert F. Freeman, Earl E. Shelton, and Arlo Ragan, Montgomery County; Edward F. Willenborg, Hamilton County; Sidney H. Mountcastle, and Gerald Union, Summit County; W. "Bill" Webb, and Miss Jean Armour, Franklin County; Howard Rempes, Mahoning County; Mrs. Gladys Davidson, Lorain County; Charles G. Greig, Butler County; Mrs. Barbara Wolfert, Erie County; Mrs. C. K. Elliott, Greene County; Robert A. Lang, Cuyahoga County;

Hart F. Page, W. Michael Traphagan, Herbert E. Gillen, and Jerry J. Campbell, of the OSMA staff; James S. Imboden, AMPAC district representative stationed in Columbus; David Weihaupt, of the AMA Field Service; plus the persons previously named as participants in the program.

Ohio is among the leading states as far as number of County Medical Societies which maintain either full-time or part-time executive staffs. In addition to those previously named, executive staffs are maintained in Lucas, Defiance, Clark, Lake, Richland, Trumbull, and Geauga Counties.

Ohio Executives in Chicago Conference



This photo shows part of the group which met in the Board of Trustees Room at the AMA Headquarters in Chicago. Extreme right, with back to camera, is Dr. Lawrence C. Meredith, OSMA President; left, with back to camera, Edward Willenborg, President of the Ohio Executives' group; extreme left, AMA Executive Vice-President F. J. L. Blasingame. Others, from left, are Howard Rempes, Mahoning County; Robert Freeman, Earl Shelton, and Arlo Ragan, Montgomery County; Patsy Jo Askins, Sandusky County; Barbara Wolfert, Erie County; Mrs. C. K. Elliott, Greene County; Jean Armour, Franklin County; and Dana Whipple, Medina County.

OSU Team Seeks Standards in Care of Newborn Babies

Dr. Alex F. Robertson, director of the newborn nursery service at Ohio State University Medical Center, heads a team of physicians and nurses who are attempting to establish a system of model care for premature infants.

The team effort is funded with $60,000 from the Ohio Department of Health and is directed at development of comprehensive nursing and medical standards to provide exemplary care of premature babies.

According to Dr. Robertson, plans are underway to make video tapes on procedures used in caring for newborns. These will include the techniques of intrauterine transfusions and exchange blood transfusions of infants endangered by RH incompatibility at birth.

Maternity classes are being held for expectant mothers as another facet of the program.

It has been demonstrated during the clinic's year of existence that home visits by nurses help mothers of premature infants to better cope with their care.

"We are convinced that every hospital involved in the care of low birth rate infants in families of low income should have a clinic, with its own nurse and pediatrician, to see such babies through the first years of life," Dr. Robertson said. "In this way many problems that occur due to prematurity can be avoided.

It is expected that the premature infant team will serve as consultants to smaller hospitals in the state for establishing or improving newborn care and facilities.

Dr. Samuel D. Goldberg, Youngstown, was elected president of the Jewish Federation of Youngstown, an organization dedicated to establishing and financing a network of local and non-local humanitarian services.

Obituaries

Ad Astra

Jacob Julian Alpers, M. D., Columbus; Tufts University School of Medicine, 1928; aged 64; died August 12; former member of the Ohio State Medical Association; member of the American Psychiatric Association. A specialist in the neuropsychiatric field for many years in Columbus, Dr. Alpers was chief neurological and psychiatric consultant in the Ohio State University Health Service, and for many years chief psychiatrist at the Ohio Penitentiary. Survivors include his widow, two sons and four sisters.

Calvin Layle Baker, M. D., Columbus; University of Cincinnati College of Medicine, 1932; aged 59; died August 25; member of the Ohio State Medical Association, the American Medical Association, and American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. A practicing physician for many years in Columbus where he specialized in psychiatry, Dr. Baker was formerly commissioner of mental hygiene for the State of Ohio. He was honorary life vice-president of the Ohio Association of Mental Retardation, and a past president of the Ohio Mental Health Association. Dr. Baker also served for many years on the Committee on Mental Health for the Ohio State Medical Association. During the early part of his career, he was a general practitioner in Cridersville. Among affiliations, he was a member of the Masonic Lodge. A veteran of World War II, he is survived by his widow, a son, his mother, and two sisters.

William B. Carmon, M. D., Norwood; University of Cincinnati College of Medicine, 1927; aged 70; died August 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Carmon began his practice in the Norwood area shortly after completing his medical education in 1927 and continued in practice until this year. Among professional activities he was surgeon for the police and fire departments. Affiliations included memberships in several Masonic bodies. Survivors include his widow and a brother.

Harold Newton Cole, Sr., M. D., Cleveland; Western Reserve University School of Medicine, 1909; aged 82; died August 20; member of the Ohio State Medical Association, the American Medical Association, American Dermatological Association and the American Academy of Dermatology and Syphilology; diplomate of the American Board of Dermatology and Syphilology. A practitioner of long standing in the field of dermatology, Dr. Cole was for many years associated with the faculty at Western Reserve University School of Medicine. He was one of the founders of the American Board of Dermatology and Syphilology and was a past president of the American Dermatological Association. A member of the Baptist Church, he is survived by two daughters, a son and a brother.

Joseph Alger Conner, M. D., Cincinnati; University of Cincinnati College of Medicine, 1919; aged 78; died August 12; member of the Ohio State Medical Association and the American Medical Association. A general practitioner of long standing in Cincinnati, Dr. Conner was associated with the Price Hill Kiwanis Club and the Men's Western Hills Garden Club. He held the rank of lieutenant colonel in the Ohio Defense Corps. His widow survives.

Claude Charles Crum, M. D., Torrance, Calif.; Hospital College of Medicine, Louisville, Ky., 1901; aged 88; died August 4; former member of the Ohio

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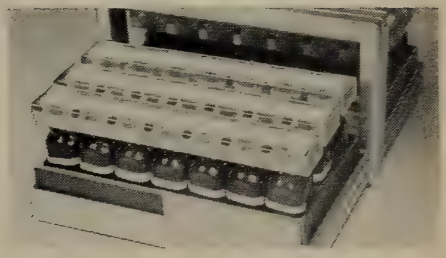
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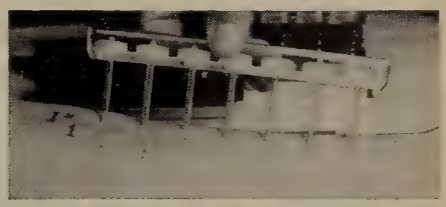
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State Medical Association. Dr. Crum practiced in Columbus from 1930 to 1948. He is survived by his widow and three daughters.

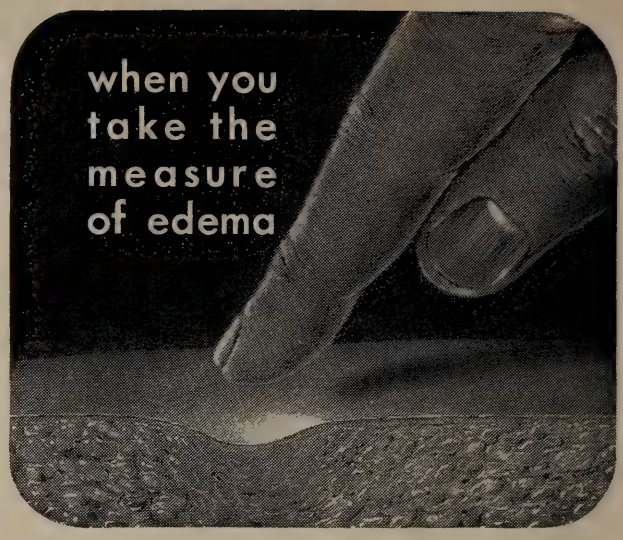
John T. Evans, Sr., M. D., Akron; Vanderbilt University School of Medicine, 1926; aged 68; died August 11; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A general practitioner in Akron since 1928, Dr. Evans served in the Army Reserve as a medical officer. Among affiliations, he was a member of the Catholic Church. Surviving are three daughters and four sons, among them Dr. John T. Evans, Jr., of Jacksonville, Florida; also three sisters and two brothers.

Richard Gilbert Hodges, M. D., Cleveland; Harvard Medical School, 1936; aged 57; died August 17; member of the Ohio State Medical Association and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Dr. Hodges was chief of the pediatrics service at St. Luke's Hospital in Cleveland, and was formerly assistant professor of pediatrics at Western Reserve University. He was a veteran of World War II, having served in the Air Force Medical Corps. Survivors include his widow, two sons, a daughter, and two sisters.

William Maurice Hoyt, M. D., Grove City; Hahnemann Medical College and Hospital of Philadelphia, 1909; aged 84; died August 25; long a member of the Ohio State Medical Association and the American Medical Association. A native of Hillsboro, where his father practiced before him, Dr. Hoyt served that community as a practitioner for more than 50 years. From 1963 to 1965 his practice was in Grove City. Dr. Hoyt was first appointed to the State Medical Board of Ohio in 1938 and served in that capacity until his resignation in 1965. He was former coroner of Highland County, was Highland County health commissioner, and served as a member of the Hillsboro Board of Education. He was a member of Phi Kappa Psi Fraternity, and several Masonic bodies. Survivors include his widow, and a son, Dr. Charles W. Hoyt, of Cincinnati.

Stanley Hrynkiewich, M. D., Cleveland; Friedrich-Wilhelms University Faculty of Medicine, 1945; aged 47; died April 18; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Anesthesiologists. Dr. Hrynkiewich was licensed to practice in Ohio in 1956 and had been a practitioner in the Cleveland area since that time.

Floyd B. Jaquays, M. D., Cleveland; University of Louisville School of Medicine, 1925; aged 67; died August 8; member of the Ohio State Medical Association and the American Medical Association. A practitioner in the Cleveland area for many years, Dr. Jaquays began his specialty practice in ophthalmology in 1944. He retired in 1962 for reasons of health. Among affiliations, he was a member of the



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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Kiwanis Club and the Masonic Lodge. Survivors include his widow and two sons.

Robert W. Kramer, Jr., M. D., Corning; Stritch School of Medicine of Loyola University, 1954; aged 40; died August 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Kramer had been a practitioner in the Corning area for six years, and previously practiced for about three years in Dayton. He was a veteran of World War II, during which he served with the Navy Air Force. A member of the Catholic Church, he is survived by his widow, three sons, a daughter, his parents, and a brother.

Paul R. Lecklitner, M. D., Canton; Jefferson Medical College of Philadelphia, 1925; aged 65; died July 28; member of the Ohio State Medical Association and the American Medical Association. A Canton practitioner for about 31 years, Dr. Lecklitner specialized in orthopaedic surgery, and was physician also for the Republic Steel Corporation. He was a member of several Masonic bodies and the Evangelical United Brethren Church. Surviving are his widow, two daughters, a son, a sister and a brother.

Robert Parker Little, M. D., Zurich, Switzerland; Ohio State University College of Medicine, 1923; aged 72; died July 7; former member of the Ohio State Medical Association. Dr. Little practiced in Columbus during the 1920's before he moved to California. He was making his home in Europe in recent years.

Elmer H. McDonald, M. D., Dayton; Ohio State University College of Medicine, 1911; aged 79; died June 22; member of the Ohio State Medical Association, the American Medical Association, and the National Medical Association. Dr. McDonald practiced medicine for some 52 years at Bloomingburg and at Washington Court House. He was making his home since retirement in Dayton with a son who survives.

Charles E. McKinley, M. D., Camden; University of Cincinnati College of Medicine, 1930; aged 64; died August 11; member of the Ohio State Medical Association. A native of Camden, Dr. McKinley served virtually all of his professional career in the Preble County community. He served during World War II in the Medical Corps and attained the rank of lieutenant colonel. For 20 years Dr. McKinley served on the local school board, and among affiliations was a member of the Presbyterian Church. He is survived by his widow, a son, and a sister.

Ralph R. Wilkinson, M. D., Cincinnati; Miami Medical College, Cincinnati, 1902; aged 90; died August 23; former member of the Ohio State Medical Association. A practitioner of long standing in Cincinnati where he specialized in obstetrics, Dr. Wilkinson retired about 20 years ago. He is survived by a daughter and two brothers.

William L. Wolffheim, M. D., Akron; Albertus University Faculty of Medicine, Konigsberg, 1913; aged 79; died August 28; member of the Ohio State Medical Association and the American Medical Association. A native of Germany and practitioner there for many years, Dr. Wolffheim came to this country in 1941 and became a citizen four years later. He practiced for 25 years in Akron, specializing in the EENT field. His widow survives.

Lions Club Funds Help Research

Research on eye diseases at the University of Cincinnati Medical Center will be supported this year by $16,000 from the Ohio Lions Eye Research Foundation. This brings to $86,500 the total given to the University's research program by the Foundation since its establishment in 1952.

The Lions' funds support the eye pathology laboratory directed by Dr. Joseph Ginsberg, where research is being conducted on birth defects and childhood tumors of the eye and effects of drug toxicity on the eye.

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

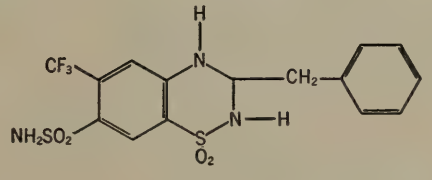
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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Activities of County Societies ...

LORAIN

A provocative title was chosen to commence the Fall activities of Lorain County Medical Society, when members and their wives met at the Aquamarine Lodge, in Avon Lake, on the evening of September 13. The featured speaker of the evening, Homer H. Stryker, M. D., of Kalamazoo, Michigan, chose for the title of his address "Backing Into Business Without Even Trying."

A total of 138 were present, including 17 guests. Continuing the policy of recent years, this September meeting was a recognition dinner for the Board of Supervisors of Lorain County Medical Foundation, and those students within the county who received scholarship grants from the Foundation to assist them in furthering their careers in Medicine and Nursing. Originally begun with surplus money from the Polio Immunization Program in Lorain County, a total of $1400 was awarded for the school year 1966-1967.

In introducing the Board of Supervisors, Society President J. A. Cicerrella, M. D., acknowledged the services and interest these community leaders have displayed in their selection of deserving students.

Following presentation of the scholarship checks, a short business meeting was conducted. Five membership applications received a first reading, and one Associate Member was elected to Active Membership in the Society. The status of one Active Member was changed on his request to Intern/Resident Membership with the approval of those present and voting, for a two-year period while engaged in further surgical training at University Hospitals in Cleveland.

Secretary-Treasurer J. B. McCoy, M. D., introduced Dr. Stryker, president of the Stryker Corporation. An orthopedic surgeon in Kalamazoo, Dr. Stryker developed his hobby of designing and making orthopedic and hospital equipment to use in his field of surgery, from a small room in his basement into what is now the Stryker Corporation, engaged in the manufacture and world-wide distribution of the products of his invention. Recipient of several citations, he is one of 12 who have been elected by the Michigan Health Council to the Michigan Health Hall of Fame. An interesting connection with Lorain County goes back to the years 1855 and 1856 when Dr. Stryker's grandfather attended Oberlin College.

Interspersed with humorous anecdotes, Dr. Stryker's theme was a timely portrayal of the "hurdles" to be encountered by those pursuing the paths of private enterprise.

LUCAS

The Academy of Medicine of Toledo and Lucas County is again sponsoring a bowling team this year. The season got under way on September 15 when five-man teams met and officially joined the Academy Bowling League.

The Academy has announced availability of a Christmas card, sales from which will help boost the Foundation Fund of the Academy.

SUMMIT

The Summit County Medical Society held its monthly meeting on September 6 at the Children's Hospital Auditorium in Akron. Speaker for the occasion was Dr. Lawrence C. Meredith, Elyria, President of the Ohio State Medical Association, who discussed various aspects of issues of vital interest to the medical profession, especially in regard to medicare, separate billing, interest in elections, organization matters, etc.

TRUMBULL

The Trumbull County Medical Society held its first meeting of the fall season on September 21 at Squaw Creek Country Club. This was a joint meeting with the ladies. A social hour and dinner preceded the program.

Speaker for the occasion was Fred Bordeaux, who is associated with the Social Security Administration.



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The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

THE COFFEE PARTY — the Postcard Party — the Dial-a-Dozen Program — are they among the coming season's social calendar of important events? Well — yes and no. Certainly they're social to a point — but the social activity they generate is secondary to their vital role in pre-election activity. Coffee Party? Postcard Party? Sounds provocative, don't you think? Let's spotlight the real significance of them in the social whirl — a whirl that has only about a month now in which to produce results. And while you're "whirling," never forget for one moment that this is a vital election year!

It might be well to remind you that before the Coffee Party program is undertaken, the candidate's campaign manager must be contacted and the project must be coordinated with the physician who is serving as the candidate's district chairman. Your objective is to make certain the party is a success and that the candidate meets all guests in a minimum of time.

Schedule the party to permit mothers to get children off to school. A typical day would schedule coffee parties at 9:30, 11:00 A. M. and 2:30 P. M. for housewives; 4:00, 7:30 and 9:00 P. M. for business girls or men, and/or couples, with an informal dinner with the community committee at 6:00 P. M. Sunday afternoon patio gatherings are good. Saturdays are generally poor choices for gatherings, but don't overlook the possibility of a group which doesn't fit the pattern.

The Coffee Party

Here are some suggestions for the hostess of the Coffee Party: Invite your guests well in advance whenever possible. In telephoning, tell them why you want them to hear your candidate. Stress the fact, where necessary, that attendance doesn't imply endorsement. A little flattery won't hurt! Tell them you know their opinion carries weight and you would like to have their estimate of the candidate.

Don't try for more than 20 to 30 people at one gathering at the very most (smaller groups, depending on your facilities, of course). If possible, make up the guest list, showing full name, address and occupation of husband. Send the list to the candidate so he has a chance to go over it. Keep the session down to an hour and a half at the very most. Set your invitation time for 15 minutes before the candidate is scheduled to arrive. Greet and seat guests and have coffee served immediately. Have an assistant write out a name tag for each guest.

See that you have an adequate supply of campaign literature. Explain to the candidate that he will speak for a few minutes and then be open to questions. Inform the group on some interesting and favorable points regarding the candidate and his family. Never permit a guest to "buttonhole" the candidate or to enter into arguments. Elaborate furnishings, food or tea services are unnecessary. The Coffee Party is an excuse for getting together, and the stress should be on easy informality and comfort. Above all, do not let the party drag — if necessary, adjourn the get-together early. Remember that at all times the hostess is captain of the ship.

The Dial-A-Dozen Program has this objective: To obtain as many people as possible to telephone on behalf of the candidate. The technique is applied by using various mailing lists from which a letter is sent asking individuals to telephone 12 of their friends. Close friends, acquaintances and neighbors are the best prospects to call. It is suggested that the caller identify herself and state she is interested in electing the candidate and that she has volunteered to call on his behalf. If the person called expresses interest and wants to help, this should be clearly indicated on the tally sheet. To make this telephone campaign most effective, the results of the calls noted on the tally sheet should be returned to the candidate's headquarters promptly.

Again it is important to remember that before taking any of the above action, the candidate's campaign manager must be contacted as well as the physician serving as the candidate's district chairman.

The Postcard Party

What is the Postcard Party and its objective? To get a personal endorsement of a candidate in the hands of every voter. This works best in small or suburban communities where people know each other. Have the party well in advance of the mailing date. Mail the cards just a few days before the election. There should be two committees: One the "preparation" group — to address cards; the second, the "signing" group consisting of prominent individuals in the community to sign the cards. The cost involved is in purchasing and printing of the postcards (if possible the cards should have a picture of the candidate) and, of course, the postage. Have coffee available and plenty of ball point pens. It's a good idea, if practical, to have the candidate stop in and



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thank everyone who has had a part in the addressing and signing.

At the risk of repeating myself, I want to say again that this is far more than just an ordinary election year. It is an election of considerable significance and importance. If you want the right man to be elected, you've got to do a lot more than vote for him, vital as that is. You've got to convince others that he is the right man. The time has long since past when doctors and doctors' families can sit back complacently and say politics is not their meat. Whether it likes it or not, the medical profession has been catapulted onto the political scene.

A Personal Plea

To local publicity chairmen! Do you want your county written up in this column so that the doctors know what you are doing? Don't you think your county auxiliary merits all the publicity it can get? Will you cooperate with me, please, by sending your newspaper clippings and any other data relating to your group to me? — each and every month!

This column designated for the October issue is shorter than usual. Auxiliaries do not meet during the summer months and this is, of necessity, being written in early September. Moreover, your reporter is vacationing in New England and she's short on material but long on colorful, incredible scenery! But if this month's column does what it is primarily intended to do — to get each and every one of you on the bandwagon of election activity and fervor — then the abbreviated length is of no moment. One last thought: Fall Conference is just upon us (October 11 and 12 in Columbus). There is so much good to be had from attending it — and even some fun! Give Ruth Wychgel and Ludel Sauvageot your support by being there . . . And give the rest of us on the State Board the chance to meet you to help you and to answer any questions you may have. We'd consider it a privilege, truly . . . Be seeing you . . .

COMING MEETINGS

Ohio State Medical Association:

1967 Annual Meeting, Columbus, May 15-19.

1968 Annual Meeting, Cincinnati, Week of May 12.

1969 Annual Meeting, Columbus, Week of May 11.

American Medical Association:

1966 Clinical Convention, Las Vegas, Nevada, November 27-30.

1967 Annual Convention, Jersey City, N. J., June 18-22.

American College of Physicians, (Regional, including Ohio), Morgantown, W. Va., January 20-21.

American Rheumatism Association, Netherland Hilton Hotel, Cincinnati, December 2-3.

Association of Physicians of the Department of Mental Hygiene and Correction, Columbus, October 14.

Disaster Institute Program, Columbus, October 30.

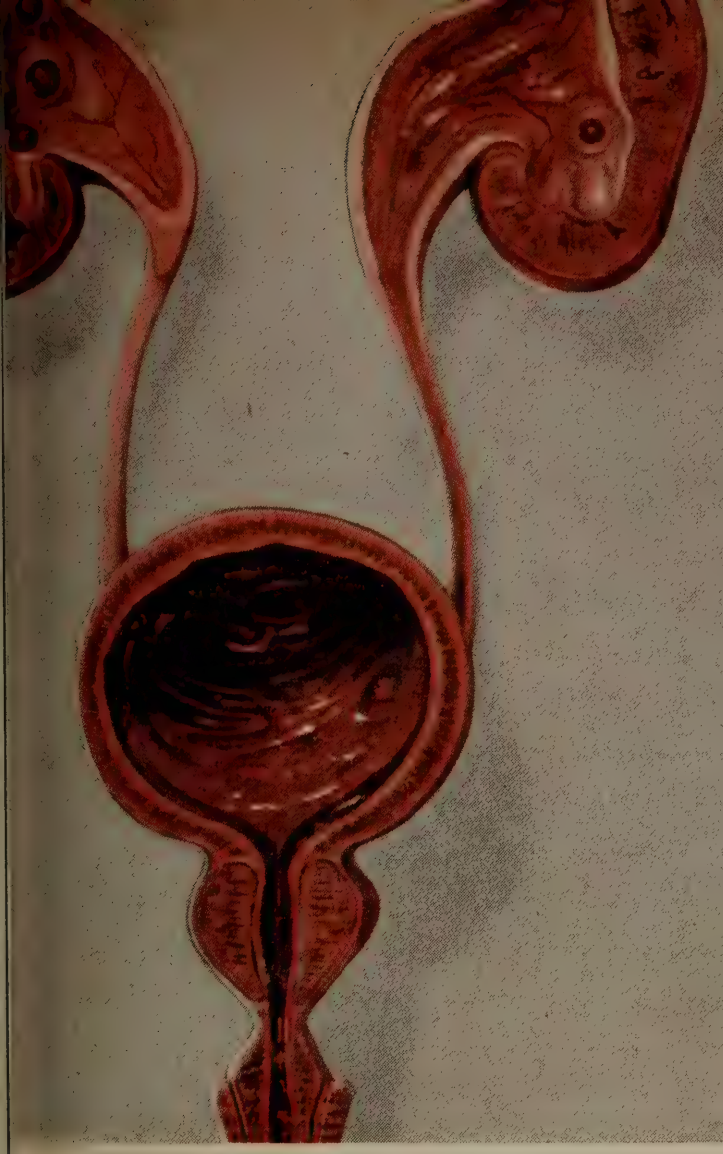
Sixth Councilor District Postgraduate Day, Akron, October 19.

Symposium on Diabetes Mellitus, Sponsored by Ohio State University College of Medicine and Central Ohio Diabetes Association, October 26, at the Fort Hayes Hotel, Columbus.

American College of Physicians Gastroenterology Program

The American College of Physicians, with headquarters at 4200 Pine Street, Philadelphia, Pa. 19104, has announced a program entitled "Progress in Gastroenterology — 1966," to be given in cooperation with the University of Pennsylvania School of Medicine, November 28 - December 2. Place is the auditorium of the Annenberg School of Communications, 3620 Walnut Street, Philadelphia.





Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

NegGram®

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

tions: Urinary tract infections caused by gram-negative and some gram-e organisms.

ffects: Mainly mild, transient gastrointestinal disturbances; in onal instances, drowsiness, fatigue, pruritus, rash, urticaria, mild phila, reversible subjective visual disturbances (overbrightness of change in visual color perception, difficulty in focusing, decrease in acuity and double vision), and reversible photosensitivity reactions. d overdosage, coupled with certain predisposing factors, has produced onvulsions in a few patients.

itions: As with all new drugs, blood and liver function tests are advis-uring prolonged treatment. **Pending further experience, like most therapeutic agents, this drug should not be given in the first trimester pregnancy. It must be used cautiously in patients with liver disease or impairment of kidney function.** Because photosensitivity reactions have ed in a small number of cases, patients should be cautioned to avoid ssary exposure to direct sunlight while receiving NegGram, and if a n occurs, therapy should be discontinued. The dosage recommended lts and children should not arbitrarily be doubled unless under the supervision of a physician. Bacterial resistance may develop.

esting the urine for glucose in patients receiving NegGram, Clinistix® t Strips or Tes-Tape® should be used since other reagents give a positive reaction.

: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times or one to two weeks. Thereafter, if prolonged treatment is indicated, sage may be reduced to two Gm. daily. Children may be given imately 25 *mg. per pound* of body weight per day, administered in l doses. The dosage recommended above for adults and children not arbitrarily be doubled unless under the careful supervision of a ian. Until further experience is gained, infants under 1 month not be treated with the drug.

upplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conve-available in bottles of 56 (sufficient for one full week of therapy) and in of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

nces: (1) Based on 23 clinical papers, 1512 cases. Bibliography on t. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: crobial Agents and Chemotherapy—1964, Ann Arbor, American y for Microbiology, 1965, p. 722.

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Socio-Economics of Health Care Topic of National Congress

The effective organization and delivery of health services will be explored at the 1st National Congress on the Socio-Economics of Health Care, January 22-23, 1967, in Chicago.

The Congress, sponsored by the Council on Medical Service and the Division of Socio-Economic Activities of the American Medical Association, will be held at the Palmer House, and will bring together authorities from medicine, health care administration, social science, education, community planning, and other disciplines to report on new issues, developments and techniques in the organization, delivery and financing of health care services.

George W. Slagle, M. D., Battle Creek, Mich., chairman of the Council, said the meeting will serve as a national forum for interchange of information and opinion among the many areas of society concerned with this subject.

Through a series of presentations and discussion session, conference participants will explore current health status of the population, impact of medical and social changes on patterns of health care, the changing role of the hospital and its medical staff in the community, new methods in training and utilization of health manpower, and financing of health services.

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Booklet on Distribution of Physicians and Hospitals

The American Medical Association recently issued a booklet entitled "Distribution of Physicians, Hospitals, and Hospital Beds in the United States," a statistical study by region, state, county, and metropolitan area.

The following figures are given for Ohio: Total number of physicians (M. D.'s) 13,293; total in private practice, 8,894; general practice, 3,343; general surgery, 869; internal medicine, 1,146; obstetrics-gynecology, 624; pediatrics, 440; psychiatry, 243.

Number of hospitals in Ohio, 192; number of hospital beds, 35,948; resident population of the state, 10,471,200; income per capita, $2,235; income per household, $7,628.

The tables contained in the booklet are intended to serve as guides for comparing regions, and other subdivisions with respect to total number of physicians, physicians in private practice by specialty, etc. Comparative figures are likewise given for hospitals, number of beds, etc. The AMA indicates that such information is of interest especially to individuals and organizations concerned with the provision of health care services.

The booklet may be ordered from the AMA for $1.00 per copy for persons in the United States, Canada and Mexico.

Ohioan Is Installed as President of National Anesthesiology Group

Dr. Nicholas G. DePiero, of Cleveland, was installed on October 5 as president of the American Society of Anesthesiologists during the society's annual meeting in Philadelphia. He succeeded Dr. John J. Bonica, of Seattle, Washington.

New president-elect is Dr. E. M. Papper, of New York City. Among other officers elected is Dr. Carl E. Wasmuth, also of Cleveland, speaker of the House of Delegates.

Colorado Springs Will Be Site Of Surgeons Meeting

All doctors of medicine are invited to attend the second of three Sectional Meetings of the American College of Surgeons in Colorado Springs, February 15-17. Sessions will be held in the Broadmoor Hotel.

Dr. Woodrow L. Pickhardt, Chicago, is in charge of Sectional Meeting programs for the College. Inquiries may be addressed to him at College headquarters: 55 East Erie Street, Chicago, Illinois 60611.

The third and final Sectional Meeting for the 1967 season will be held in New York, February 27 - March 2.

The 1967 annual Clinical Congress of the College will be held in Chicago, October 2-6.

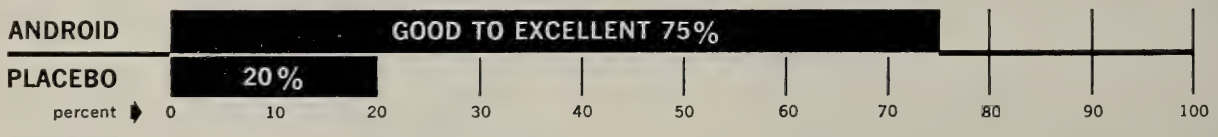
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Licenses for Practice in Ohio Issued by State Board

Results of the examinations conducted by the State Medical Board of Ohio on June 16 to 18 were considered by the board at its meeting on August 22.

Dr. William T. Washam, executive secretary of the board, reported that certificates to practice medicine and surgery were awarded to 306 graduates of schools of medicine. Fifty-six graduates of osteopathic schools were authorized certificates to practice osteopathic medicine and surgery. Also 41 chiropodists were authorized to receive certificates in their field.

In the limited practice branches, three were awarded certificates to practice physical therapy, 25 to practice chiropractic, four to practice massage, and two to practice cosmetic therapy.

Highest grade in the examinations for doctors of medicine was made by Donald G. Rau, Cincinnati, a graduate of the University of Cincinnati College of Medicine, with an average of 91 per cent.

The second highest grade of 89.8 per cent was made by Albert M. Iosue, Cleveland, a graduate of Western Reserve University School of Medicine; and third highest was made by John R. Burg, Painesville, a graduate of Ohio State University College of Medicine, whose percentage was 89.5.

In August the board also announced that 106 doctors of medicine had been licensed to practice in Ohio through endorsement of their licenses to practice in states having reciprocity with Ohio, or through certification by the National Board of Medical Examiners.

National Library of Medicine Expands Computer System

Dr. Martin M. Cummings, director of the National Library of Medicine, in Bethesda, Maryland, recently reported on progress toward expansion of MEDLARS (Medical Literature Analysis and Retrieval System), and discussed the awarding of a contract aimed at determining specifications for enhancing and extending effectiveness of the system.

The continuing information explosion in the biomedical sciences and the increasing need for improved communications among members of the medical community is a major concern, Dr. Cummings said. The study will include investigation of new areas for applying the computer capabilities; mechanization of the library's card catalog and serial records; development of drug information module; storage and retrieval of graphic images, etc. Millions of pages are being microfilmed each year.

At least one medical school in Ohio is sending librarians to the Washington area to study the MEDLAR System, another indication of expanding interest in this field.

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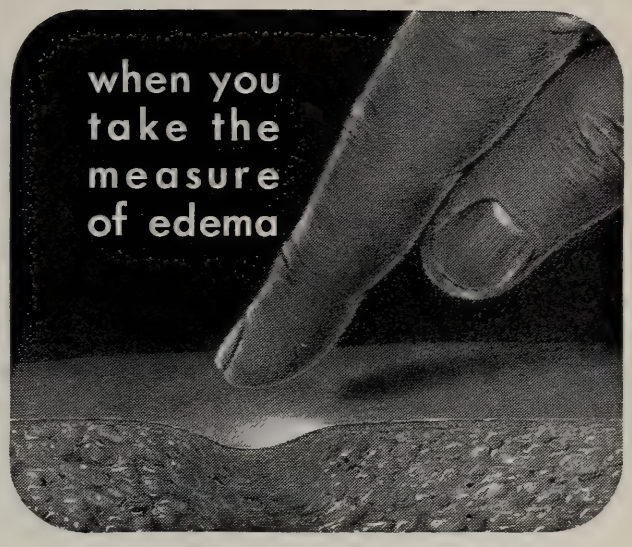
Physician's Bookshelf

Handbook of Clinical Laboratory Data, edited by Henry C. Damm, Ph. D., and John W. King, M. D., Ph. D., ($12.50, *The Chemical Rubber Co., Cleveland, Ohio).* Desiring to aid in the conduct of medical practice and research, the editors have brought together in one volume a distillation of the enormous literature on this subject. It was conceived as a companion publication of the *Handbook of Chemistry and Physics.* Within the limits they assigned themselves, the editors have done an excellent job. Although the organization of the text seems a little difficult at first, one suspects it would be easier to find his way around after using the book for a while. It is well indexed, and the matter is clearly and concisely written.

A unique feature is the inclusion of systematic flow sheets for the evaluation of glandular, organ, and system functions. Starting with the beginning signs and symptoms of organ dysfunction, an attempt is made to demonstrate the laboratory findings in various clinical conditions leading to a differential diagnosis. Unfortunately, these flow sheets are a little difficult to follow and contain some errors (e.g., high T-3 red cell uptake and high thyroidal uptake of radioactive iodine are listed as screening tests for thyroid hypofunction). In this reviewer's opinion, these flow sheets detract from an otherwise excellent text. The book should not be considered a substitute for a textbook of medicine, but it should prove to be a valuable addition to the library of the practicing physician.

The Practical Manual for Clinical Laboratory Procedures, edited by Henry C. Damm, Ph. D., and John W. King, M. D., Ph. D., ($12.50, *The Chemical Rubber Co., Cleveland, Ohio)* This is a loose-leaf book, which the editors intend to update continuously by inserts to be published quarterly. It is a companion publication of the *Handbook of Clinical Laboratory Data* consisting of a compendium of clinical laboratory procedures. Nicely printed and clearly written, it is divided into six easily recognized sections, viz.: Blood Bank, Chemistry, Hematology, Histology, Microbiology, and Urinalysis. Its chief value will be for the use of laboratory technicians and those physicians personally involved in laboratory work.

A seminar on mental health was held in Van Wert in mid-September under joint sponsorship of the Van Wert County Health Foundation and the local chapter of the Academy of General Practice representing Paulding, Van Wert and Mercer Counties. The theme was "Recognizing Mental Illness in the Child."



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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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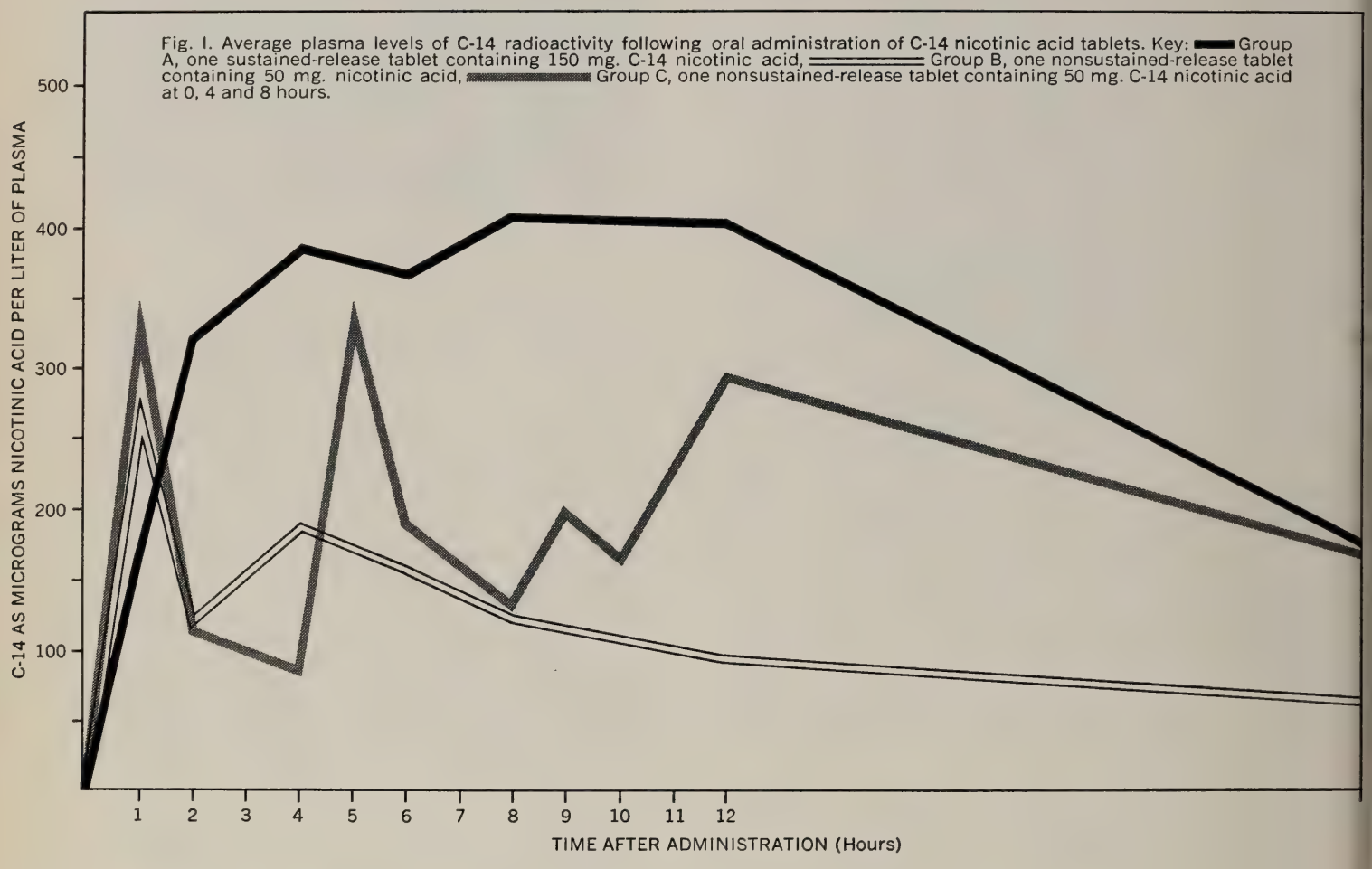
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Detroit, Michigan 48234

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

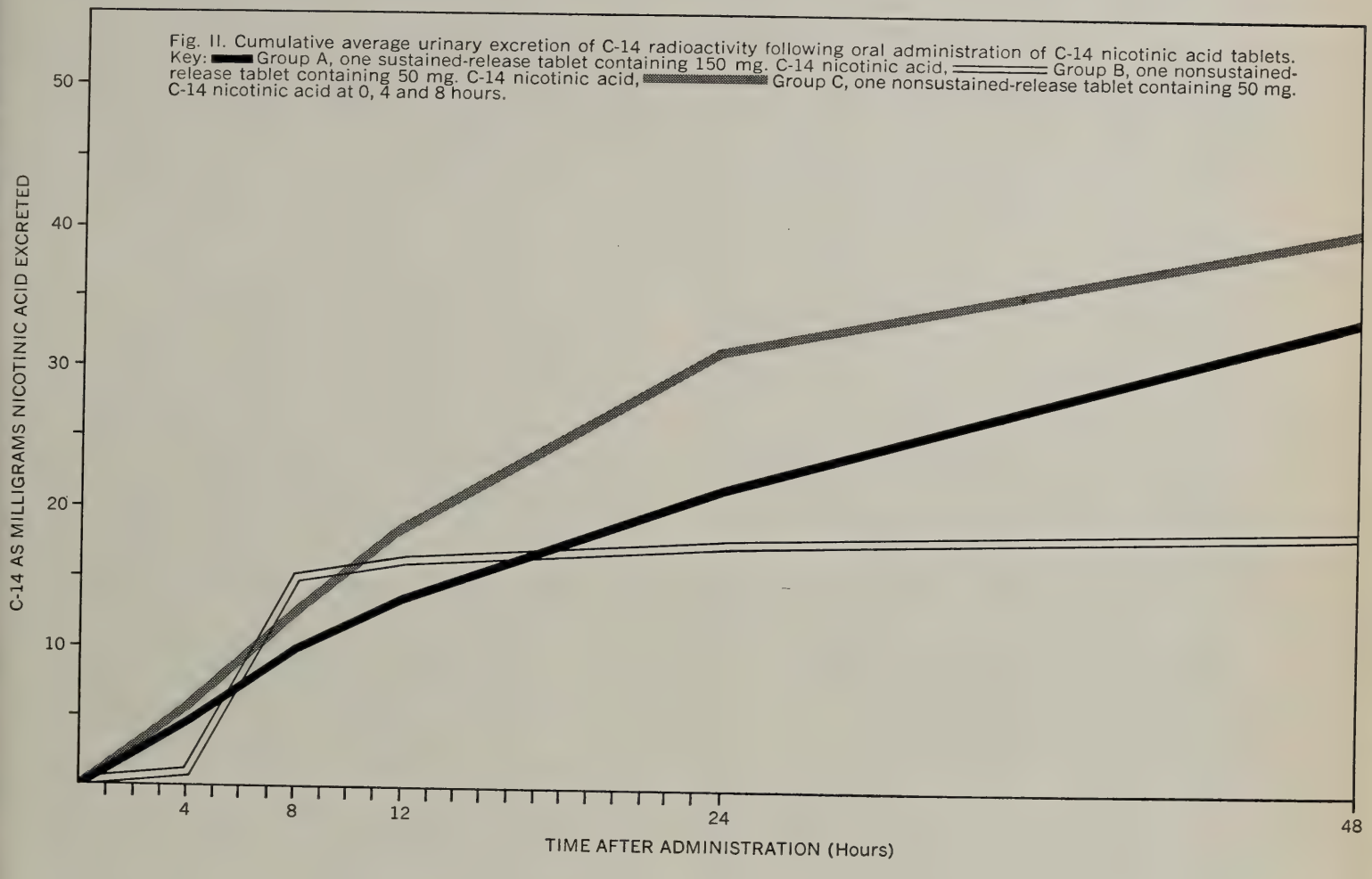
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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In Our Opinion

Comments on Current Economic, Social And Professional Problems

THE BUREAUCRAT AND THE DOCTOR

A spokesman for medicare, commenting on a report that doctors have raised their fees for elderly patients by "as much as 300 per cent" since the program began, jumped to a hasty and predictable conclusion. "This is a situation," he told the *New York Times,* "in which the professional takes advantage of the plan."

President Johnson has lent credence to this charge by ordering a study of rising medical costs.

Ever since George Bernard Shaw, the Fabian socialist, wrote "The Doctor's Dilemma," advocates of government controlled medicine have tended to blame the doctors for everything that has gone wrong in their profession.

What the *Times* report boiled down to was simply that many doctors who have been treating the elderly and indigent at cut-rate fees, out of consideration for these patients, are raising the fees to conform to their standard fees. "I'm not raising fees," one doctor protested, "but eliminating a discount."

This doesn't strike us as unreasonable. There is no reason why a doctor who has been helping elderly patients by charging less than the going rate should now be expected to grant the same subsidy to the government — especially when he is paying social security taxes himself for benefits which, in all likelihood, he will never receive. Doctors rarely retire at 65, and with today's shortage there is more need than ever for them to stay on the job.

If the government, for its part, wants the elderly to receive the quality of care that they have been promised under the voluntary, supplemental program to which nearly all of them have subscribed, it hardly makes sense for it to refuse to pay what other patients pay.

This isn't to say that all doctors are perfect or that there won't be any abuses on their part. But when a government spokesman suggests that the medical profession is profiteering simply because doctors object to subsidizing the government more than they already are, the doctors can't be blamed for looking at the whole program with a jaundiced eye.

This is the way schisms have developed between doctors and bureaucrats wherever a government has stepped into the practice of medicine. If it is an indication of the way things are to be here, too, the prognosis for medicare is a gloomy one. — *The Chicago Tribune.*

SOME INTERESTING BACKGROUND ON CHIROPRACTIC FACULTIES

An article in the September 19 issue of *The Journal of the AMA* presents some revealing information on the qualifications of faculty members of chiropractic schools in this country and in Canada.

Information presented is from a survey made by the AMA's Department of Investigation based on data printed in catalogs of 13 "approved" chiropractic schools. *JAMA* comments as follows on findings of the investigators:

"It is submitted that this study proves the inadequacy of the quality of chiropractic school faculties as gained from information in their own school catalogs. It confirms a statement by the former director of education of the American Chiropractic Association, who said:

" 'Too many instructors [in chiropractic schools are] teaching the basic sciences without having had any advanced or graduate training in these sciences. Too many instructors [are] not trained or qualified as teachers nor masters in their fields, resulting in slavish devotion to textbook teaching and instruction considerably below the level of postcollege professional education.'

"As seen from the table, more than 50 per cent of the faculty members do not have recognized four-year academic degrees, and 23 of 126 recognized academic degrees listed by faculty members were not confirmed by the granting institutions. Also, 228 of the total of 267 faculty members listed the 'spurious' D. C. degree.

"It is not surprising, therefore, that no chiropractic school is accredited by any recognized educational accrediting agency in the United States."

The report speaks for itself, and the AMA is to be commended for this excellent study and a forthright presentation of the facts.

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Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
Before prescribing or administering, read product circular with package or available on request.

Two Columbus Physicians Launch Preschooler Nutrition Study

A national nutrition survey of preschool children has been launched from Children's Hospital, of Columbus, under the direction of George Owen, M. D., and Carl Nelsen, M. D.

Dr. Owen, principal investigator, is head of Children's new Nutrition Division and associate professor of pediatrics in the Ohio State University College of Medicine. Dr. Nelsen, head of the Hospital's new Renal Division, is an assistant professor in the College.

Financed under a five-year grant from the Federal Children's Bureau, the survey has a first-year budget of $160,000. It is the first of its kind conducted in this country among preschool children. Studies in other countries have shown this age group to be particularly vulnerable to nutritional deficiency diseases.

The survey is beginning with a pilot study of children from lower-income families, where major problems are expected, and will expand to include preschool children from all income groups.

The first children seen include some receiving care in Children's Outpatient Department. The researchers will gradually work out from the Hospital as procedures and techniques are refined.

Drs. Owen and Nelsen expressed the hope that the survey may be launched on a national scale by the third year.—Adapted from "Pediascript," Bulletin of Children's Hospital, Columbus.

American Motorists Among Safest Drivers the World Over

Though more Americans are being killed in motor vehicle accidents than ever before, United States motorists are probably the world's safest — in at least one important category.

Based on figures for 1963, the United States' total of 52.6 deaths per 100,000 registered vehicles was low for the 20 nations whose figures were compared.

New Zealand, with a 53.8 average, was the only nation that approached this country's record.

"Unsafest" country, according to the figures, was Japan, whose toll was nearly eight times as high as that of the United States. Finland, Italy, and Austria had death rates about five times as high.

The registered vehicle mortality rate in Japan was 402.2; in Finland, 261.2; Italy, 257; and Austria, 242.9.

In many countries where statistics are most grim, blame generally is placed on a too sudden influx of automobiles driven by relatively inexperienced drivers on poor roads regulated by inadequate laws.

Meanwhile, lest American drivers become complacent, WHO figures showed that the motor vehicle accident death rate in this country per 100,000 population has been rising steadily since 1961. — *Health Insurance Institute.*

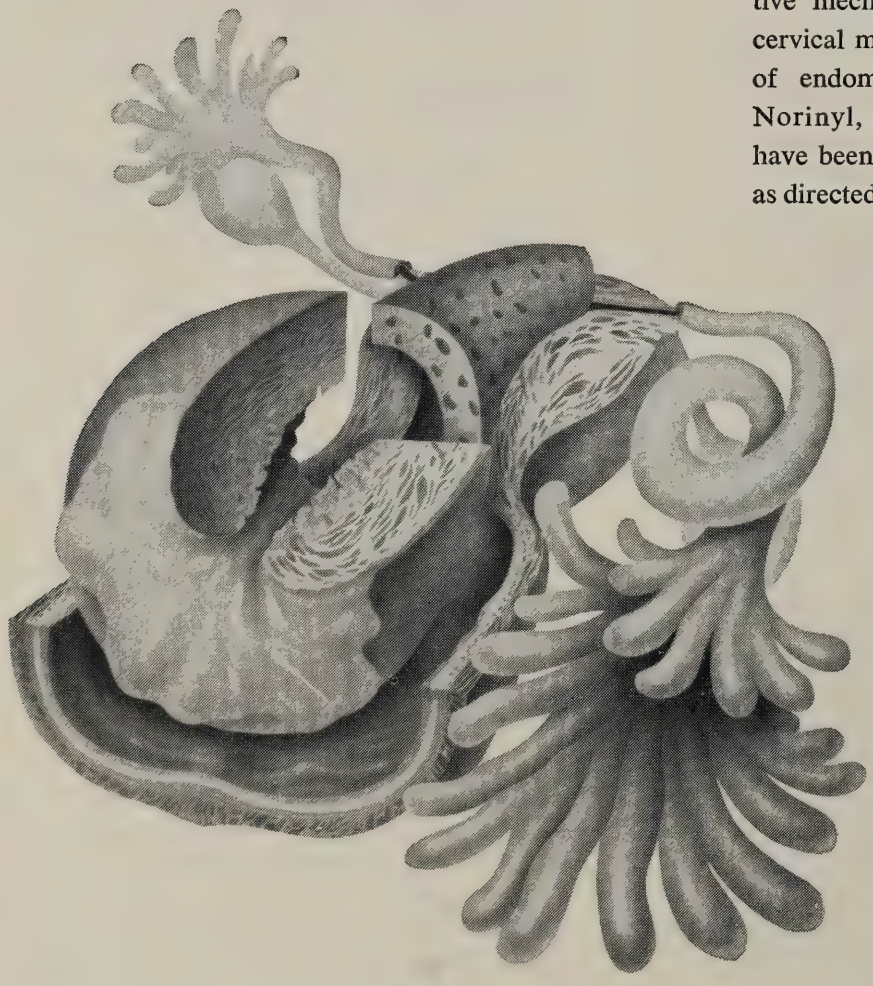
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for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

This extended formula, completely compatible with the infant, has demonstrated its advantages over older modified-milk formulas in intensive clinical tests.[1-4]

It provides:

OPTIMUM CONTENTMENT.
New Optimil's marked superiority in achieving satiety–reflected by infants' infrequent crying—is most reassuring to mothers.

OPTIMUM DIGESTIBILITY.
New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

OPTIMUM GROWTH.
New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Optimil is recommended as regular feeding for optimum growth and development of normal newborns; as an ideal supplement to or replacement for breast milk; as sound nutrition for prematures; and as prophylaxis against both essential fatty acid and nutritional iron deficiency.

Optimil, diluted 1 to 1 with water, provides a standard feeding formula—20 calories per oz. Supplied in new, convenient 16-oz. cans, Optimil is available for your specification at leading drug stores.



The complete Optimil system available to hospitals includes: 5% Glucose Water in presterilized 4-oz. disposable bottles • Optimil 13 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil 20 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil Concentrated Infant Formula in 16-oz. cans • Sterilized disposable nipples • Optimil Gift Pack: six 4-oz. disposable bottles of Optimil 20 calories/oz. Prepared Formula* and one 16-oz. can of Optimil Concentrated Infant Formula.

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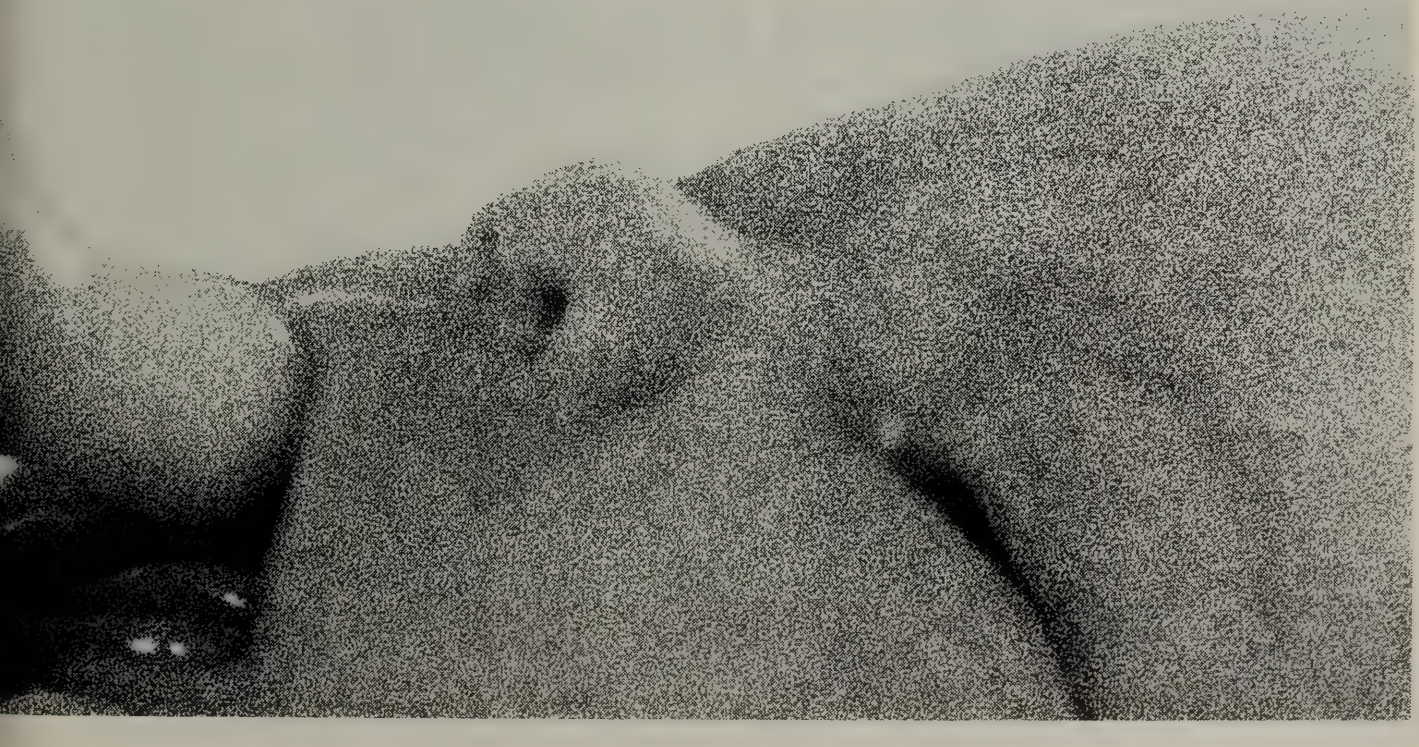
1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

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New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during August and September. List shows name of physician, county, and city in which he is practicing, or temporary addresses for those taking graduate work:

Allen
Homer H. Cheng, Lima

Belmont
Felipe V. Lavapies, Tiltonsville
Calvin B. Monte DeRamos, Barnesville

Clark
William I. Goettman, Springfield

Cuyahoga
Abdoollah Bidar, Cleveland
Gene W. Boychuk, Cleveland
Roland D. Carlson, Cleveland
Angelo B. Cordova, Cleveland
Alexander S. Dowling, Jr. Cleveland
Richard L. Dunn, Cleveland
Lungee G. Dy, Cleveland
Edgar J. Filson, Cleveland
Emmett W. Hilton, Cleveland
George D. Kiperman, Cleveland
Vladamir D. Korba, Cleveland
Reuben S. Lorenzo, Cleveland
Stewart N. Nickel, Cleveland
Eugenia B. Perez, Cleveland
Cahit Plaantekin, Berea
Barry S. Yulish, Cleveland

Franklin
James Q. Dorgan, Jr., Columbus
Imanta V. Freimanis, Columbus
Edward E. Huston, Columbus
Paul F. Keith, Columbus
Eugene R. Perrin, Columbus
Samuel L. Portman, Columbus

Hamilton
Flavio Amongero, Cincinnati
Seymour B. Bronstein, Cincinnati
Mark G. Carroll, Jr., Cincinnati
Georges Daoud, Cincinnati
Patrick H. Lagan, Cincinnati
Leo H. Munick, Cincinnati
Robert H. Poe, Cincinnati
Harry C. Roach, Cincinnati
Anthony J. Salem, Cincinnati
Abbot G. Spaulding, Cincinnati

Holmes
Daniel J. Miller, Walnut Creek

Jefferson
James V. Current, Steubenville

Lorain
Richard F. Runser, Elyria

Mahoning
Ilarion N. Dombczewsky, Youngstown

Montgomery
Merle E. Gibson, Dayton
Theodore Hirsch, Dayton
Paul Kezdi, Dayton
Francesco M. Salerno, Dayton
Layton R. Sutton, Dayton

Summit
Josephine C. Aronica, Akron
Vasant A. Chand, Akron
John M. Dunn, Akron
James S. Reef, Akron

Socio-Economics of Health Care, Topic for January Program

The Council on Medical Service and the Division of Socio-Economic Activities of the American Medical Association will sponsor the First National Congress on Socio-Economics of Health Care on January 22-23, 1967, at the Palmer House in Chicago. The Congress will bring together authorities from medicine, health care administration, social science, education, community planning and other disciplines to report on new issues, developments, and techniques in the organization, delivery and financing of health care services.

"Silent World, Muffled World" is the name of a color, sound film for showing to civic, educational, voluntary and professional health groups, including medical and paramedical professions. This is one of a number of films available from the Public Health Service Audiovisual Facility, Atlanta, Georgia 30333; Attn: Distribution Unit.



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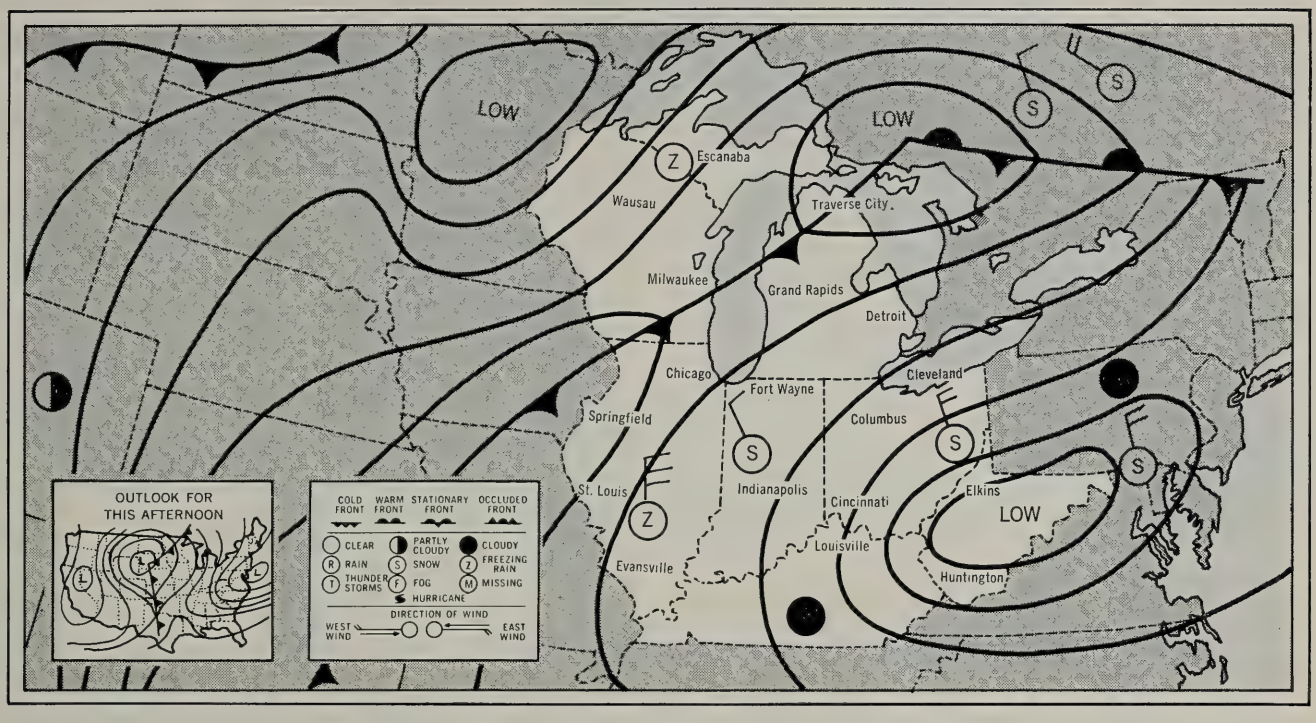
Your local Credit Bureau has for you the credit histories of almost every adult and family in your community. And, your local Credit Bureau needs to know your credit experiences — for the good of your fellow creditors — — for the good of the credit seeker.

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Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. *Side effects:* Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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Ohio State to Conduct Studies On Accident Prevention

What is reported to be the first U. S. Public Health Service-sponsored graduate training program in the United States to prepare researchers for work in air and highway transportation accident prevention is getting under way this fall at Ohio State University.

Four university departments — industrial and civil engineering, preventive medicine and aviation — are joining in the program which is supported by a $330,000 five-year grant from the Accident Prevention Grants Division of the U. S. Department of Health, Education, and Welfare.

Director of the program is Thomas H. Rockwell, Ph. D., professor of industrial engineering and principal investigator on a number of highway transportation research projects during the past several years.

Also involved in the project is Charles E. Billings, Jr., M. D., assistant professor of preventive medicine, and others.

The Ohio State program is the first of its type announced by the HEW and one of three in the nation scheduled to be funded by that agency.

Dr. Rockwell said Ohio State was chosen to conduct the project because it is one of the top two or three universities in the nation in terms of on-going research in transportation safety.

As evidence of the state of Ohio's commitment to a long-term program of transportation research at Ohio State, it has recently provided $2,000,000 for the aquisition of land for the development of a Transportation Research Center including specialized test highways for research purposes.

The center will be located on a 5000-acre site in central Ohio on Route 33, midway between Marysville and Bellefontaine. Purchase of the land is only the first step in the project. Establishment of a $25 million Transportation Research Center is scheduled on the tract, to be operated by Ohio State University College of Engineering.

Employment of Handicapped Award Goes to Dayton Physician

Dr. Herman J. Bearzy, of Dayton, was named Physician of the Year by the President's Committee on Employment of the Handicapped for his work in behalf of the hire-the-handicapped program in the Dayton area.

The award was presented at the meeting of the American Medical Association Council on Occupational Health in Portland, Oregon. Since Dr. Bearzy was attending another meeting in Boston, the award was accepted in his behalf by a colleague, Dr. John N. Aldes, of Los Angeles, who received the same award himself in 1959.

Dr. Bearzy is director of the Department of Physical Medicine and Rehabilitation at Miami Valley Hospital in Dayton. Among his numerous affiliations, he is a member of the Dayton Mayor's Committee and the Ohio Governor's Committee on Employment of the Handicapped.

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Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M.D., M.P.H.*

PART V

(Continued from October Issue)

SO SERIOUS was the diphtheria in those days there were no less than 23 antitoxin stations, many of them in pharmacies throughout the city. There were nearly 400 cases in 1919, a low year.

On the not-so-glorious "Rhine of Cincinnati" Dr. Peters notes with pleasure in this same year (1919) that it is "soon to be drained. The conditions of the canal described by Dr. Landis years ago are practically the same today. The water polluted and turbid . . ."

An interesting SOS is noted in November, 1919:

The mortality from diarrheal diseases in children under two years is at a standstill. Up to the present time a steady decline has been noted. It is not unlikely that there is some relationship between this increase in the death rate in New York City and the high cost of milk. Pure cow's milk is the ideal food for babies after they have been weaned. Let us do all that we can to increase production and consumption of clean, pasteurized cow's milk . . .

Health Condition Among Draftees

An extract from a paper by Colonel M. P. Ravenel, Professor of Preventive Medicine in the University of Missouri, captured national attention. It was read before the annual meeting of the American Public Health Association in 1919. Dr. Peters published an extract of the paper in the CINCINNATI SANITARY BULLETIN for December, 1919. Colonel Ravenel points out that,

The draft made it possible for the first time to ascertain the physical condition of young men throughout the country. Of 5,719,152 men 21 to 31 years of age examined, 1,680,175 or 29.35 per cent were found unfit for military duty on account of physical defects. A certain number of these defects were considered remediable or had been remediable in their incipiency. Other countries in the war have had like experiences. The Premier of Great Britain has recently said that but for the loss of the physically unfit, one million more men could have been put in the field. We cannot maintain an A-1 country unless our population rates A-1 . . .

Fakes and Fakers and Other Matters

On "Fakes and Fakers" Dr. Peters wrote with some feeling regarding a certain "Dr. Emma Adams who, posing as a physician, worked up quite a practice . . ." Among medicine man medications of a bizarre nature, Mrs. Adams did a thriving business (that was before the law caught up with her) dispensing essence of "Chicken Livers" said to be good for whatever ails you.

And on saccharine, he was not less pointed, as he wrote:

Let us not be misled by unscrupulous advertisers suggesting the use of saccharine to relieve the inconvenience and suffering during the sugar shortage. Saccharine is a coal tar derivative, not a food, and has no food value whatever. We shall continue to prosecute if saccharine is substituted for sugar . . .

On anti-venereal medication he proclaims that,

One of the greatest hindrances to the forces which we have marshalled to combat venereal disease is the most obnoxious advertisement of "sure cures." Certain steps have been taken to neutralize the pernicious effect of it by the substitution of plain, sound, sensible information and advice issued by Federal, State, and Municipal Boards of Health. The contraction of a venereal disease usually implies a moral blunder. To neglect prompt and proper treatment is always a disastrous mistake . . .

The classifications system for restaurants was adopted that year. Under "A," "B," "C," and "D," the latter referred to "cheap restaurants serving 15¢ and 20¢ meals." [no less]

1920 — Narcotics

In his opening cannonade for 1920, Dr. Peters noted that,

The enforcement of the Harrison Narcotic Law undoubtedly has done much to lessen drug addiction but unfortunately no provision is made, even in the amendments of 1918, for the drug addict, the principal affected, as a result of which he and his family are the victims of the "trafficker," "vendor," "morphine doctor," and "dope apothecary" to such an extent that he is forced to petty thievery and his dependents reduced to want.

[The question is current if the approach to the problem under the Harrison Act is "best," or ought

(Continued on Page 1143)

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.
Submitted March 16, 1966.

the United States substitute the "British Approach" which is "more permissive and less punitive," and tends to cut out completely the nefarious traffic in drugs at exorbitant cost to the addict?] K. I. E. M.

The 12th Street Health Center

On the role of the 12th Street Health Center, Dr. Peters notes:

It is not too much of an extravagance to assert that the combination of health activities at the health center is a measure of pioneering in public health work which will be of great and permanent benefit to the people of Cincinnati. Until January 1, the building had been occupied by the Anti-Tuberculosis League. The dispensary and nursing service have been taken over by the Cincinnati Health Department. The premises offering ample facilities for the centralization of other departmental agencies, we have worked out a plan for that purpose. It is our wish and desire that the health center be a clearing house of health information, the focus as it were, which should bring together all community agencies dealing with the health of the people . . .

Alcohol

And on the evils of alcohol, especially "wood" alcohol, he warns:

Special warning of the tragic consequences which may follow the use of wood alcohol, denatured alcohol, and medicated alcohol for beverage purposes, has been sent broadcast and sounded in the daily press. The harmful action of this poison and the cumulative effect is noticeable shortly after exposure. One teaspoonful taken internally may cause blindness . . .

Trachoma Survey

In March, 1920, a Trachoma Survey was conducted by the Department in cooperation with the United States Public Health Service and the Ohio Department of Health. The prevalence of the disease was estimated, for example, as 33,000 in the State of Kentucky alone. (There were 134 cases found among 52,000 school children.)

And on the problem of whether "movies hurt the eyes" Dr. Peters notes,

It is safe to say a person may witness a picture lasting about an hour and a half each day without straining the eyes, but eye discomfort in the movies should be regarded as a danger signal and should lead the sufferer to the doctor's office for an examination . . .

[What would he say now about the hours upon hours of TV we 'enjoy'?]

The Public Health Nurse

And more and more on milk and the growing child, on botulism, and on the role of the public health nurse, about whom he says among many other things:

The public health nurse bears a conspicuous integral relation to the rapid evolution of community health ideals. She is learning to administer *all* the community needs, with a happy blending in her duties, in service to the expectant mother, the well baby and the sick baby, and the tender child of preschool age. She assists the school physician in his medical inspection . . . She is a valuable assistant in the TB dispensary, and visits the homes of the tuberculous patients radiating sunshine and good cheer. It is here that she is able to render valuable social service by suggesting remedies for the social and economic conditions which underlie the causes of disease.

Industrial Health and Other Subjects

On industrial health and particularly on the dangers of breathing "rock dust," he urges: "If in your place of employment such health hazards as have been described have not been eliminated or minimized by the installation of blower systems, condensers and the like, notify the Health Commissioner at once . . ."

The Joy of Giving and the Dollar

On the "Joy of Giving," he notes that

The Community Chest Campaign, April 5 - 14 for a minimum budget of $1,875,000 presents a splendid opportunity to all citizens of Cincinnati and Hamilton County. The Community Chest drive is to care for 70 local charitable and Social Service organizations, and to provide our quota for Foreign Relief . . .

And on what the dollar could purchase in those days,

In 1919 the Division of Laboratories with a personnel including a chemist, bacteriologist, and two assistants, examined over 30,000 samples submitted — all for an annual appropriation of a mere $6,460.

Housing

And on public housing he notes that,

Under the Housing and Town Planning Act of July 9, 1919, 500,000 houses are to be built. In his speech on housing, the King of England (no less) says: "It is not merely houses that are needed. The new houses must be homes. Can we not aim at securing to the working classes in their homes the comfort, leisure, brightness and peace which we can usually associate with the world 'home'?" The Board of Health has been invited to send representatives to this most important congress in London, but we have been forced to reply in the terms of the colored man who was asked to loan his friend $10: "Thanks for the compliment."

Malnutrition and TB

And again on tuberculosis, noting that the Anti-Tuberculosis League continues to render good service, Dr. Peters adds: "Malnutrition among school children is one of the principal predisposing causes conspiring to maintain the army of susceptibles . . ."

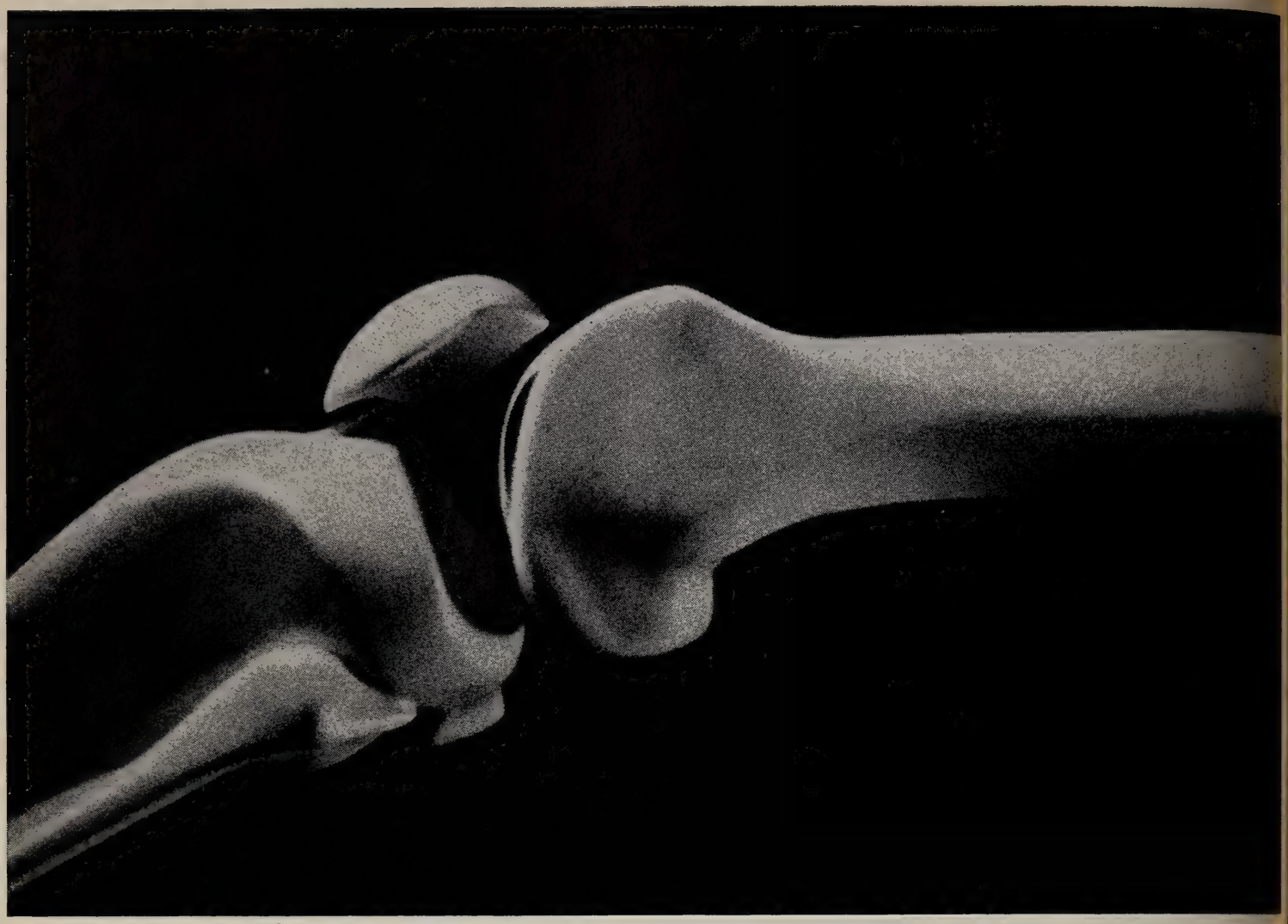
And on "Peace Gardens," he writes: "The devotee of open-air bears the stamp of religion on his face. The garden hobby is a priceless aid to health . . ."

And on ophthalmia neonatorum, he reminds his readers that, "The Health Department maintains a supply of silver nitrate solution for free distribution to physicians and midwives . . ."

Health Commissioners Meet

On May 12, 13, and 14, 1920, the First Annual Conference of District Health Commissioners was held in Columbus at the "New Southern Hotel." The program included discussion of the milk problem, public health administration in cities, and other phases of public health work. A special feature was an address by the Honorable James M. Cox, Governor of Ohio. "Boards of Health are required to pay the expenses . . ."

(Continued in December Issue)



Butazolidin® alka

phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
6509-V(B)

Also available: Butazolidin®, phenylbutazone Tablets of 100 mg.

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Geigy

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectable
(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.

CI-GP-69-R2

WARNER-CHILCOTT Morris Plains, New Jersey

Extensive Cancer Survey Study Underway at Ohio State

Examination of indigent women of Franklin County for detection and treatment of cancer of the cervix is underway in the Ohio State University Medical Center, Columbus. The project is funded by a $474,000 grant from the U. S. Public Health Service, payable over a five-year period.

According to Drs. John C. Ullery and Emmerich von Haam, codirectors of the project, 30,000 women are expected to participate each year. Dr. Ullery is chairman of the Department of Obstetrics and Gynecology, while Dr. von Haam is chairman of the Department of Pathology.

Indigent women over age 20 are eligible. Candidates may be referred from all the clinics at Ohio State, Planned Parenthood Center, Columbus State Hospital and county and state penal institutions.

Dr. Samuel L. Portman will be assistant director of the project, aided by Dr. G. W. Lewis, chief resident physician in the Department of Obstetrics and Gynecology.

Each woman, except those who are pregnant, is asked to collect secretion specimens at home using a cytopipette. Laboratory findings using the cytopipette will be compared with those found using standard examination techniques.

All women in the project will be followed for up to five years with periodic re-examination. The medical team is assisted by social workers in the follow-up appointment making.

American Heart Association Honors Cleveland Research Physician

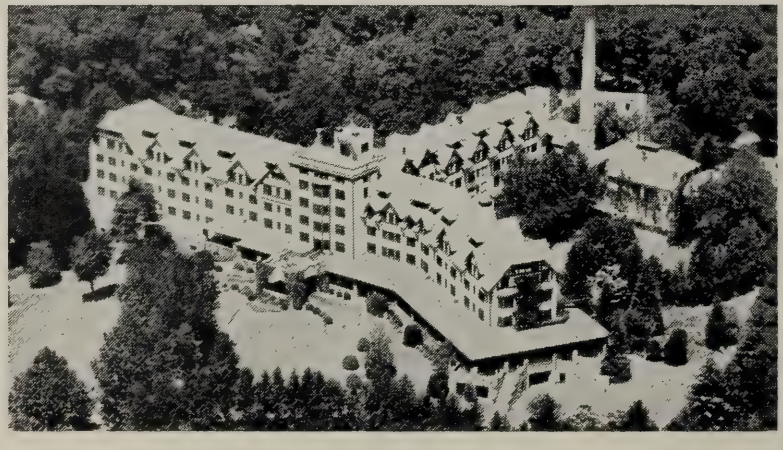
For the third time this year Dr. Harry Goldblatt, of Cleveland, was honored for his outstanding contributions in the research field. The American Heart Association's $1000 Research Achievement Award was presented to him for his pioneer studies in the field of high blood pressure. Setting for the award was the AHA annual meeting in New York on October 21-25.

Only recently Dr. Goldblatt was named co-winner of the newly founded Stouffer Prize for research in arteriosclerosis and hypertension. Last March he received the Gold Headed Cane Award of the American Association of Pathologists and Bacteriologists.

Dr. G. Douglas Talbott, Dayton, was guest speaker at the Oakwood Kiwanis Club dinner meeting where he spoke on the topic, "The Role of Computers and Automation in Heart Attacks."

Dr. Robert A. Vogel, Montgomery County health commissioner, addressed the Riverdale Kiwanis Club at a dinner meeting on the topic, "A Unified Health District Is Overdue."

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Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

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"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert

References: 1. Simpson, G.M.: Postgrad. Med. *39*:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: *65*:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. *25*:553, 1961. 7. Sainz, A.: Psychosomatics *5*:167, 1964.

PROLIXIN®
SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB 'The Priceless Ingredient' of every product is the honor and integrity of its maker.

Article in Ohio Newspaper Emphasizes Troubles in British Health Service

UNDER THE HEADING, "Health Service Mess Adds to Wilson's Troubles," *The Plain Dealer,* leading Cleveland newspaper, published the following article in its September 25 issue. The article, reproduced here by permission, was dispatched from London and carried the by-line of W. Holden White.

* * *

LONDON — In the truckload of trouble worrying Prime Minister Wilson, one mess currently costing him points in opinion polls is the rotten condition of the socialized health service.

Never a healthy child, this product of the Attlee administration is now, at the end of its teen-age span, a sick, steadily declining, badly nursed juvenile.

Even the very leftist *New Statesman* titled a Page 1 editorial on the topic "The Ailing Health Service." The British Medical Association, officially doing an ethical and so far as possible conscientious job urging doctor-members to try to keep the program going, is at its wit's end.

AS ONE BMA member privately commented: "If we have to handle anything like an epidemic of anything, heaven help all of us."

To a dozen other major problems is now added the worst one any government has met since the health service was blasted off in 1948: a large-scale revolt among young doctors comprising hospital medical staffs. They are resigning, operating go-slows, emigrating, persuading pals to keep out of British medicine. The worst of these disasters is emigration of recently qualified young medics.

According to the *New Statesman,* emigration rate of doctors now exceeds the rate of output of newly qualified interns from three large medical schools. As this happens, the number of new medics joining hospital staffs takes a stiff dive on account of other emigrants getting out of Wilsonian Britain without even giving the British hospitals a trial. A recent exam for interns who had applied to take their skill to the United States drew nearly twice as many as expected.

A SAD-FACED Harley Street consulting specialist, said: "Who should blame them? They have a 120-hour work week compared with 42 for a dockworker or construction worker. Their take-home pay isn't much more than the dockworker or builder. In the United States, Canada, Australia, South Africa, they are offered jobs for decent remuneration."

The result of these defections is an alarming increase in the size of hospital waiting lists. The total at 3,000 state-run hospitals is now over 500,000. All the services you get free on the socialized system; for example x-ray, physiotherapy, pathological examination, are reduced and are to be cut back further.

MORE SERIOUS, many hospitals actually have to close accident wards at times because there are no medics to treat patients. When this happens to a guy run over by a bus, or hurt in a fire, he is shunted off to another hospital.

Most serious, patients are now sometimes unable to get into hospitals for a major operation till it is too late. A Midlands woman was diagnosed as having incipient cancer. The high probability was that immediate treatment would have saved her life. She did not get it, and died. Medical authorities who must be nameless assure us that this is far from an isolated case.

THE LAST STRAW was the failure of the Wilson regime to implement a promise to pay doctors more. Long ago they raised hob about pay and conditions. The prime minister promised a big salary boost. This mollified the medics. Temporarily, the quitter quota eased off. But the promise was broken like a matchstick under the excuse of the national wage freeze. From that point the queue of medical emigrants at travel bureaus thickened like a fox's brush.

In the place of emigrating British doctors hospitals are hiring colored medics, mainly Pakistanis, Nigerians and Indians, who come to the United Kingdom to study medicine at recognized medical schools and colleges with the object of taking their knowledge back to their native lands.

UNBELIEVABLE as it may seem, leprosy is actually on the list of diseases showing incidence increase in Britain since 1964. Others are hookworm, typhoid, dysentery and tuberculosis. These, especially TB, are now flourishing — typhoid and dysentery in spasmodic epidemics, TB and hookworm in steady growth. Another frequently appearing is smallpox, albeit in a mild form. However, in the summer of 1966 it was severe enough to cause European governments to insist that British tourists should produce certificates of vaccination and/or immunity. A colleague of ours, with connections in the Harley Street and just plain Doc Smith zones, says: "I am 58 and I never heard of this happening to a holder of a British passport before."

The Conservatives built new hospitals, expanded existing ones. The Socialists have stopped the construction program, except in a few cases where it has been cut back. Because of the staff scarcity they actually are closing sections of hospitals all over the place.

This is a picture of the health service after two years of what Wilson in the party platform called "purposive planning."

OSMJ Scientific Section

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Immunologic Deficiency States

A Review

JAMES I. TENNENBAUM, M. D.

IN THE past few years, great progress has been made in the understanding of the nature and development of the lymphoid cell system and its function in the production of serum antibodies and development of delayed (cellular) hypersensitivity. The thymus has been shown to play a significant, if not the major, role in the origin and integrity of the lymphoid system and adaptive immunity. Several excellent review articles on thymic function are available[1-3] and, therefore, a detailed discussion concerning this important structure will not be presented here. It is the purpose of this review to present the clinical and laboratory features of the primary syndromes involving the immune system which result in pronounced susceptibility to repeated infections.

The Immunoglobulins

It is now recognized that there are four classes of distinct, but structurally related serum proteins whose main function is to act as antibodies. The largest proportion of these proteins migrate electrophoretically in the region commonly designated as γ-globulin. In addition, serum proteins with β-globulin mobility have been demonstrated to contain antibody activity. For this reason the term immunoglobulins has been applied to these proteins. Chart 1 presents the World Health Organization[4] suggested nomenclature for these proteins, and some of the commonly used synonyms.

CHART 1. *Immunoglobulin Terminology*

W.H.O.	ALTERNATIVE	SYNONYMS
γG	Ig G	7 S γ-globulin, γ_2-globulin γ_{ss}-globulin
γA	Ig A	γ1A, B_2 A globulin
γM	Ig M	γ_1 M globulin, B_2 M globulin, 19S- γ-globulin
γD	Ig D	

γ-G constitutes approximately 71 per cent of the total serum immunoglobulins.[5] It is the only immunoglobulin that crosses the human placenta. It has a molecular weight of about 160,000 and a sedimentation constant of 7 Svedberg units. Most antibacterial and antiviral antibodies are present in this fraction.

γ-A constitutes about 21 per cent of the immunoglobulins and does not cross the placenta. However, large amounts appear in the external secretions of the body.[6] It is of interest that the majority of reaginic (allergic) antibodies have been localized in the γ-A fraction.[7] Some bacterial and viral antibodies and isohemagglutinins have also been found in this fraction.[8,9] γ-A has a molecular weight of approximately 160,000 to 500,000 and sedimentation constant between 7 and 15.

γ-M constitutes about 7 per cent of the immunoglobulins and does not cross the placenta. These antibodies are generally the first antibodies produced

The Author

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Submitted March 4, 1966.

following primary immunization, and they diminish once a strong antibody response occurs. It should be noted, however, that typhoid "O," Wassermann, and heterophile antibodies, the majority of isohemagglutinins, rheumatoid factor, and cold agglutinins are γ-M antibodies.[10] γ-M has a molecular weight of 1 million and sedimentation constant of 19.

γ-D was discovered only recently and constitutes about 0.2 per cent of the total serum immunoglobulins.[11] It has a Svedberg constant of 7. No information is available at the present time regarding the antibodies present in this fraction.

Structural analysis and genetic studies have established that the immunoglobulins are made up of at least two types of polypeptide chains, each of which is under separate genetic control.[12,13] Figure 1 is a schematic diagram of a γ-G molecule. One chain known as the light or L chain is common to all the immunoglobulins and accounts for their similarity. There are two types of L chains (designated Kappa and Lambda), identified on the basis of distinctive immunochemical properties and peptide composition. The presence of the Kappa chains determines that an immunoglobulin molecule is type K or I. Lambda chains confer type L or II properties. An L chain has a molecular weight of approximately 20,000. Bence-Jones proteins are identical to L chains except that they are dimers of the chain. The other distinct chain is a heavier chain or H chain and appears to be unique for each class of immunoglobulin. This chain has a molecular weight of 55,000 and is responsible for the skin fixation, complement fixation, and placental transfer of a given immunoglobulin.[14]

Syndromes involving deficiencies of the various immunoglobulins may be either primary or secondary (chart 2). The primary immunoglobulin deficiency syndromes may be divided into two major groups — the agamma or hypogammaglobulinemias and the

CHART 2. *Immunologic Insufficiency States*

1. IMMUNOGLOBULIN DEFICIENCY
   - *A.* Agamma or Hypogammaglobulinemias
     Usually all immunoglobulins involved.
     1. Congenital sex-linked type (Bruton)
     2. Agammaglobulinemia with Lymphopenia (Swiss type)
     3. Congenital sporadic type
     4. Late onset hypogammaglobulinemia (adult)
        a. Idiopathic
        b. Secondary
     5. Transient or Physiologic type
   - *B.* Dysgammaglobulinemia —
     Deficiency of Specific immunoglobulins with normal or increased concentrations of the other immunoglobulins

2. CELLULAR IMMUNITY DEFICIENCY
   - *A.* Primary
     1. Wiskott-Aldrich syndrome
   - *B.* Secondary
     1. Hodgkin's Disease
     2. Sarcoidosis

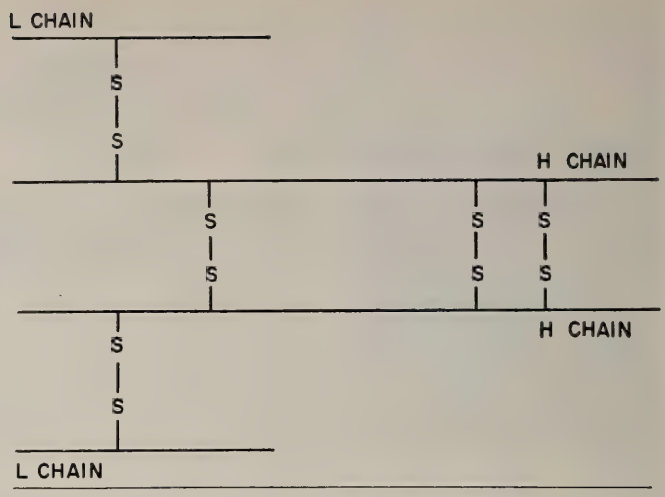


FIG. 1. *Schematic Diagram of γ-G Molecule.*

dysgammaglobulinemias. The hypogammaglobulinemias may be divided into three main groups — congenital, acquired, and the transient or physiologic types.

Congenital Hypogammaglobulinemia

The classic Bruton type was first described in 1952.[15] The disease is inherited through a congenital sex-linked recessive gene and, therefore, affects males only. Bacterial infections become a problem about the age of 5-6 months. Major infections are pneumonia, septicemia, pyoderma, conjunctivitis, suppurative otitis media, and meningitis. Viral infections are usually tolerated quite well except for infectious hepatitis, which is generally fatal for these patients. There is a complete absence of pharyngeal lymphoid tissue as well as very poor development of lymph nodes.

The serum gamma globulin levels are from 0 to 50 mg. per 100 ml. but usually are below 25 mg./100 ml. Janeway and Gitlin believe that individuals with a level above 150 mg./100 ml. do not belong to this particular group.[16] All of the immunoglobulins are lacking. In addition, these patients may have neutropenia. There are no measurable isohemagglutinins and, therefore, this laboratory test may be used as a screening procedure. Circulating antibodies are almost totally lacking. However, delayed hypersensitivity is normal. Gamma globulin catabolism is normal or delayed. The half-life of γ-G is around 23 days in normal subjects but in these children it may be lengthened to 4 to 6 weeks.[17]

The main pathologic finding is the absence of pharyngeal lymphoid tissue, Peyer's patches, and appendiceal lymphoid tissue. There are no plasma cells although a few lymphocytes may be present. The thymus appears normal.[18] An interesting complication has been the development of acute lymphatic leukemia in three of these children.

Agammaglobulinemia With Lymphopenia

The lymphopenic or Swiss type of agammaglobulinemia, the most severe type, was first described in

1950.[19] There is suggestive evidence that this disease is inherited as autosomal recessive type as both boys and girls may be affected. There has been a high incidence of consanguinity in the families of these children. In some families, the syndrome may be inherited as a sex-linked recessive trait.[20] An important clue to the correct diagnosis of this entity is the fact that these infants have growth failure from birth and actually have serious infections in the very first weeks of life. Bacterial infections are common; however, fungal and viral infections are particularly troublesome. It is in these children where smallpox vaccination may be followed by fatal generalized vaccinia. If these children live long enough, ulcerative colitis and a malabsorption syndrome may occur.[21]

Pertinent physical findings are the complete absence of tonsillar tissue and palpable lymph nodes. The serum gamma globulin level is usually below 25 mg. per 100 ml. but may range up to 50 mg. There are less than 1000 lymphocytes per cc. of blood. In addition to not being able to produce circulating antibody, there is good evidence that these patients have a failure of delayed hypersensitivity and homograft rejection.[22] Pathologic examination has shown a very marked deficiency of lymphocytes not only in the blood stream, but also in the bone marrow, lymphoid organs, and lamina propria. The thymic tissue resembles the embryonic epithelial anlage suggesting that the primary cause of this syndrome may be a failure of development of this anlage of the thymus. Despite therapy with gamma globulin and attempts at thymic transplants, all of these children have died before the age of 18 months.

Congenital Sporadic Form

Another type of agammaglobulinemia occurs in both male and female children in sporadic fashion. Familial studies suggest that this form is inherited as an autosomal recessive trait.[23] The onset of recurrent infections is in early childhood, usually between 2 months and 4 years of age. Without a family history of agammaglobulinemia, one cannot absolutely differentiate this syndrome from the congenital sex-linked type in a male. However, significant positive physical findings are that in one third of the cases splenomegaly is present and in one sixth there is lymphadenopathy and the gamma globulin levels may be slightly higher in this type, up to 400 mg. per 100 ml. As a group, this syndrome may be differentiated from the sex-linked form by a more frequent occurrence of small amounts of γ-M and γ-A and low titers of isohemagglutinins. Generally, reticuloendothelial hyperplasia is seen on biopsy material.

Late Onset Hypogammaglobulinemia

Primary late onset hypogammaglobulinemia may be defined as hypogammaglobulinemia occurring after the age of 4 years and not associated with an underlying disorder. The usual age of onset, however, is 30 to 50 years. The disease occurs in both males and females. There is strong evidence to suggest that this disease may not be "acquired" but rather inherited on a genetic basis.[24] Occasionally there are adult patients with this syndrome in which there is a high incidence of collagen diseases, abnormal antibodies suggestive of a collagen disease (ie, positive LE preparations, positive rheumatoid factor, etc.) without clinical evidence of disease, hypogammaglobulinemia, and hypergammaglobulinemia in their families. It has been suggested that the inherited trait may express itself in many ways with hypogammaglobulinemia being one of them. Physical examination usually offers no particular clues to the diagnosis.

Prior to the onset of symptoms, the immune systems apparently are normal. However, after onset of the disease there is poor antibody response to antigenic challenge. Up to 20 per cent of these patients may develop a sprue-like syndrome. The serum gamma globulin level is in the range of 10 to 20 mg. per 100 ml. with all three immunoglobulins usually diminished. Plasma cells are absent from the bone marrow and lymph nodes, which often lack germinal centers.

It is apparent that there is a great deal of overlapping between the congenital sporadic form and the late onset type and in some cases no clear-cut definition is possible.

Secondary Acquired Hypogammaglobulinemia

This type will be mentioned only briefly. By definition, the secondary forms are due to diseases that do not involve the immune system primarily. The majority of the patients have blood dyscrasias or diseases characterized by abnormal losses of the serum proteins. One third to two thirds of patients with chronic lymphatic leukemia have hypogammaglobulinemia and account for a large number of the patients in this category. Other diseases associated with secondary hypogammaglobulinemia are multiple myeloma, Waldenström's macroglobulinemia, nephrosis, and protein losing enteropathies.

Transient or Physiologic Type

During the first few months of life, the majority of circulating antibodies in a baby are those that are transmitted from the mother's circulation via the placenta. During this time, the baby's immune system matures and is able to perform its vital role. If, however, the maturing process is not quite adequate, the total immunoglobulins may drop to very low levels between the fourth and twelfth week after birth. The absolute amount of gamma globulin is not quite as important as the type and amount of specific antibodies transmitted to the infant from the mother. The infants may have recurrent diarrhea, septicemia, and meningitis. Occasionally, it may be very difficult to differentiate a male with the congenital type from the physiologic type if the gamma

globulin levels are markedly low. Only observation will afford the absolute diagnosis. The newborn infant is unable to manufacture γ-A until the third to sixth weeks of life and may not have normal adult levels for several years. γ-M is present in minute amounts in most newborns. Serum levels rise quite quickly, reaching adult levels by 9 months of age. γ-G levels reach adult levels by 2 to 3 years.[25]

The Dysgammaglobulinemias

The dysgammaglobulinemias are syndromes in which there is a deficiency of a specific immunoglobulin in the presence of normal or increased amounts of the other immunoglobulins. Several types of specific immunoglobulin deficiencies have been described. γ-A deficiency occurs physiologically in the newborn. Several cases of isolated deficiency of this immunoglobulin have been reported in otherwise healthy adults.[26] Such a deficiency has also been described in ataxia-telangiectasia. An isolated deficiency of γ-G has also been noted and was accompanied by repeated infections. No isolated deficiency of γ-M has been reported to date. Several cases of patients having deficiencies of two immunoglobulins have also been reported. These have been markedly diminished γ-A and γ-G with normal γ-M[27], and minute amounts of γ-A and γ-M with normal γ-G.[28] These cases have also been accompanied by repeated infections.

Plasma cells may be absent, present in small numbers, or present in relatively large amounts. The exact mechanism for the occurrence of these isolated syndromes is unclear. The most attractive theory has been proposed by Fudenberg and Franklin.[13] These workers suggested that there is a genetically determined inability to synthesize the various components of the immunoglobulin molecule similar to the mechansim involved in the hemoglobulinopathies. It has also been postulated that these syndromes represent varying degrees and types of cellular maturation arrest.[29] However, this seems doubtful in cases with normal appearing plasma cells.

A very interesting disease associated with a dysgammaglobulinemia is ataxia-telangiectasia which is characterized by a progressive cerebellar ataxia, oculocutaneous telangiectasia, and frequent infections, especially sinopulmonary infections.[30] It is a familial disease probably transmitted by an autosomal recessive gene and, therefore, affects both sexes equally. The symptoms begin in early childhood. The neurologic manifestations are often first. Death usually occurs before adolescence. Physical examination reveals bulbar conjunctival telangiectases and telangiectases about the neck, face, anticubital and popliteal fossae. Frequently, there is stunted growth. The striking abnormality of the serum immunoglobulins is the almost total absence of γ-A, with a low or normal γ-G and normal γ-M, although a few cases have been reported in which the γ-A was normal or elevated.

Some of the patients have a decreased ability to produce antibodies. In a large percentage of the patients, there is an absence or inability of response to delayed hypersensitivity phenomena. At present, there is no known direct correlation of the immunologic abnormalities and the neurologic manifestations or pathology. The lymph nodes are usually abnormal with poorly developed lymphoid collars around the germinal centers. In a few cases, plasma cells have been lacking. Thymic tissue may be absent and, if present, resembles the embryonic epithelial thymus with sparse lymphocytes, no cortex, and no Hassall's corpuscles. There is also a high incidence of lymphoreticular malignant changes complicating this disease.

Cellular Immunity (Delayed Hypersensitivity)

Delayed hypersensitivity can be divided into two classic types.[31] One is induced by infection and the other results from exposure of the skin to a variety of substances. The term "delayed" refers to characteristics of the elicited reactions rather than time sequence pertaining to induction of the hypersensitivity. Classic examples of delayed hypersensitivity are the PPD reaction, fungal reactions, and contact dermatitis. Present evidence seems to indicate that it is this type of phenomenon that is primarily responsible for homograft rejection.[32] The cells specifically responsible for mediating delayed hypersensitivity are unquestionably of "lymphoid origin."[31]

Sarcoidosis and Hodgkin's diseases are diseases which are associated with a loss of cellular immunity. Another syndrome associated with an abnormal immune capacity apparently involving cellular immunity is the Wiskott-Aldrich syndrome. This syndrome is transmitted genetically as a sex linked recessive trait and, therefore, involves males only. The syndrome is characterized by eczema, thrombocytopenia, and recurrent bacterial and viral infections. Immunoglobulin synthesis appears normal with normal serum immunoglobulin levels. There is a good antibody response to antigenic challenge although the isohemagglutinins may be slightly decreased. Plasma cells appear normal although there is an absolute lymphopenia. Induction of delayed hypersensitivity is extremely difficult. The lymphoid tissue shows reticular cell hyperplasia with a deficit of mature lymphocytes. It is felt, therefore, that there may be a deficit in the development of the lymphoreticular systems.[33]

Conclusion

In the past decade, great strides have been made in the classification and understanding of the many syndromes associated with immunologic deficits. In patients with unexplained recurrent infections, measurement of the antibody response to various antigenic stimuli is indicated. If the response is impaired, immunoelectrophoresis, quantitation of the serum immunoglobulin, and thorough evaluation of the lymphoreticular system is indicated to determine the type of deficit involved.

ADDENDUM

Since this paper was submitted for publication, data have been published which strongly suggest that reaginic (allergic) antibody is carried in a fifth immunoglobulin.[34] The nature of this new immunoglobulin has not yet been completely elucidated and therefore it has not been officially named.

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MYOPATHY IN ALCOHOLISM. — A characteristic clinical syndrome and associated group of biochemical abnormalities were observed in cases of chronic alcoholism studied within forty-eight hours after acute alcoholic intoxication. The features of this syndrome were as follows: muscle tenderness, cramps and weakness; myoglobin or related proteins in the urine; increased serum creatine phosphokinase activity; poor lactic acid response to ischemic exercise; variable muscle phosphorylase activity; and recovery in two to four weeks. The disorder resembles hereditary phosphorylase deficiency, or McArdle's syndrome, but is reversible.

Except for its clear temporal relation to excessive drinking, and its reversibility when drinking stops, the pathogenesis of the syndrome is unknown. Several possible mechanisms are discussed. — Gerald T. Perkoff, M. D., Patrick Hardy, M. D., and Enrique Velez-Garcia, M. D., St. Louis, Mo.: *The New England Journal of Medicine*, 274:1277-1285, June 9, 1966.

Hypersensitivity Diseases Of the Lung

A Review

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AS PROGRESS is made in medical science, physicians are becoming more aware of the many forms in which hypersensitivity manifests itself in the respiratory tract. The hypersensitivity is of both the immediate and delayed types and varies from the well defined to the obscure. This article is intended to discuss the pathophysiology and etiology of some of these disease processes.

Asthma

Asthma is an episodic disease process characterized by expiratory dyspnea, overinflation of the lungs, cough, expiratory wheezing and rhonchi. These findings are attributed to partial bronchial airway obstruction. This obstruction represents a narrowing of the lumen, occurring primarily in the smaller bronchi distal to the portion containing cartilage. This narrowing is due to (a) excessive tenacious mucus which accumulates in the lumen, (b) edema and vascular engorgement, as well as proliferation of the glands of the bronchial epithelium, and (c) constriction of smooth muscle in the bronchial wall, decreasing the cross-sectional area of the bronchi.

The primary effect of a decrease in the lumen of the bronchi and bronchioles is to increase the resistance to air flow. In large airways, slight irregularities in the lumen result in turbulence which contributes most to the rhonchi that are present. In small airways, viscosity of the gas is important in determining the amount of resistance to airflow. Ordinarily, with quiet normal inspiration, the bronchi elongate and dilate. On expiration, the process is reversed with relative airway constriction. Thus, it is apparent why impingement of the airway manifests itself most readily on expiration. The airways become obstructed early in the expiratory phase of respiration and the air is trapped in the alveoli.

A consequence of the airway obstruction is an increase in the residual air in the lung, with a corresponding decrease in inspiratory and expiratory reserve. Vital capacity may be decreased during an acute attack. Tidal volume is increased. The timed vital capacity is decreased, generally being less than 75 per cent of the vital capacity in the first second. Maximal breathing capacity is frequently decreased to 50 to 75 per cent of that anticipated because of the inability to move the air rapidly enough. There is reversible impairment of intrapulmonary gas mixing. During the asymptomatic phase, pulmonary function studies may be completely normal, and usually are.

Signs and Symptoms

Initially, asthma tends to occur in intermittent attacks. However, in many patients, the attacks become remittent. The patients are frequently found sitting in a chair, leaning forward to help force their diaphragms up on expiration and allow for greater inspiratory reserve. These patients are generally diaphoretic and very anxious. With inspiration, there is diaphragmatic contraction with elevation of the ribs and retraction of the intercostal spaces. Accessory muscles are tense and participate in the respiratory effort. Expiration is somewhat forceful as opposed to normal passive expiration. The chest does not return to the relaxed volume, as the trapped air overexpands the lungs. The patients generally exhibit a tachycardia and increased systolic blood pressure. Neck vein distention and paradoxical pulse may be present. In severe, refractory cases, the patients may appear cyanotic, exhausted, agitated or confused, and dehydrated.

Audible wheezing is frequently prominent and rhonchi can usually be felt. On percussion, the chest is hyper-resonant and the diaphragms typically are low and move poorly. On auscultation, breath sounds

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are faint and obscured by musical or wheezing rhonchi. These are primarily expiratory.

Children may have right middle lobe collapse. In patients with progression to CO_2 intoxication and narcosis, there may be altered consciousness, papilledema, hyper- or hypo-reflexia and muscle twitching. These patients tend to become adrenalin resistant.

Etiology and Types

Asthma is generally considered to be of three basic types — (1) extrinsic, (2) intrinsic, and (3) mixed. Extrinsic asthma is commonly considered synonymous with allergic asthma. This syndrome is often related to hypersensitivity to airborne allergens such as the pollens of grass, trees, and weeds as well as dust, molds, and animal danders. Less often, foods, other inhalants and drugs, such as aspirin, are incriminated. Extrinsic asthma generally occurs in the early decades of life in atopic patients with an allergic family history who demonstrate skin sensitizing antibodies by skin testing. Allergic asthma may be seasonal if caused by the pollens of trees, grasses or weeds. It may occur at any time if caused by dust, molds, danders or other nonseasonal allergens. Frequently, these patients give a history of having experienced "hay fever" during the same season in previous years or having noted sneezing or nasal congestion when in contact with house dust, moldy environments or in proximity to certain animals. This finding usually represents a progression of their allergic disease to involve the lower, as well as the upper respiratory tract. In some instances, it seems to represent an increase in the total allergenic load.

Atopic patients develop a special nonprecipitating, thermolabile antibody called reagin which fixes to the skin and mucous membranes as well as the smooth muscles of the lungs and intestines. Reagin, previously thought to be an IgA antibody, now appears to be of the recently described IgE type. It, in addition to skin and mucous membrane fixation, circulates in small quantities. Contact with the implicated antigen or antigens results in antigen-antibody reactions with release of intermediary substances (probably including histamine, serotonin, and acetylcholine) which precipitate the bronchial changes implicated in asthma. Reagin tends to locate near mast cells. It is postulated that the antigen-antibody reactions injure the mast cells and that they release most, or all, of the intermediary substances. It is probable that this reaction is initiated in the small bronchioles with subsequent involvement of the entire respiratory mucosa.

As approximately one tenth of our population is atopic, it is easy to see why allergic asthma afflicts large numbers of people. Segal states that 70 per cent of asthma in the 5 to 15 age group is due to inhalants as compared to 50 per cent between the ages of 15 and 40, and 10 per cent over 40. Inhalant allergy is an uncommon cause of asthma under the age of five.

Intrinsic asthma generally begins in the later decades of life without a family history of allergic disorders or evidence of specific sensitivities. Precipitating factors include infections, emotions, smoke, toxic agents, climatic changes, various odors, etc. This type of asthma, is, in general, more severe and debilitating. Chronic bronchitis tends to be closely related to this condition, perhaps playing an integral part. This problem is frequently associated with varying degrees of obstructive pulmonary emphysema as the years progress. These changes may, in part, reflect the inflammatory component of this disease process.

Commonly, these patients suffer from chronic rhinitis or rhinosinusitis with aggravating, frequently infected, posterior nasal drainage. They are disabled by the low humidity in heated rooms in the winter and the high humidity in the summer. Forty per cent humidity is ideal for these patients. It has been postulated that emotional or neurogenic asthma may be mediated by neurogenic stimulation of mast cells in the lungs, with subsequent release of histamine.

It has been estimated that up to 90 per cent of attacks of "asthma" in children under five years of age are related to infection. However, many experts choose to diagnose many of these cases as bronchitis or bronchiolitis with a bronchospastic component. Thus a debate rages as to what is asthma and what is infection with airway impingement. Freeman found that, in his series, 57 per cent of prepubertal asthmatics lost their disease before or during adolescence. Those with hay fever and perennial rhinitis were more apt to retain their allergy into adolescence. Those developing asthma at a later age had a much poorer prognosis. It should be noted that those with childhood "infectious asthma" are more likely to lose their disease. Atopic patients frequently develop new allergies as the years pass. Asthma may recur at a later age.

Of note is the fact that frequently "normal flora" is cultured from expectorated bronchial mucus. Actually, the normal flora of the pharynx is quite abnormal in the lower bronchial tree. The academic battle rages as to whether patients are hypersensitive to the infectious organisms, whether the infectious process makes the patient more sensitive to environmental changes and irritants, or, indeed, a subclinical state is converted to clinical allergy. H. Influenza, Hemolytic Streptocci, Pneumococci, Para-influenza, and Klebsiella are most frequently considered pathogenic in infectious asthma.

Mixed asthma involves a combination of the two types discussed. Most frequently, the process starts as pure allergic asthma with secondary intrinsic-type involvement. However, it is fairly common for a respiratory infection to precipitate the first in a series of asthma attacks held to be allergen mediated. Some observers have postulated that infections convert subclinical to clinical allergies. As mixed asthma progresses, factors such as infection, weather and emotion

assume a more dominant role and the inhalant allergens, although still exacerbating and aggravating the process, tend to assume a secondary role.

Serotonin release in patients with carcinoid syndrome is known to cause asthmatic symptoms. It has been observed that pulmonary emboli are associated with wheezing bronchospasm which has been attributed to the release of serotonin from platelets. Also, some patients have been observed who develop bronchospasm following abnormal histamine release on exercise or under emotional stress. Cholinergic drugs and insecticides, as well as nitrogen dioxide fumes, all can precipitate bronchospastic attacks. Bradykinin has also been noted to initiate an asthma-like syndrome.

Laboratory Evaluation

Chest roentgenograms commonly demonstrate darkened lung fields with low diaphragms. The ribs tend to be elevated with widened interspaces. It is important to rule out pneumonitis, pneumothorax and foreign body or tumor obstruction, and emphysema. The EKG may demonstrate right-side strain or hypertrophy patterns. The hemogram may manifest a moderate polycythemia in patients with recurrent asthma. During acute attacks in patients with an allergic component, eosinophils may be increased. They usually comprise less than 15 per cent of the white blood cells. Sputum examination may disclose a large number of eosinophils (in all types of asthma) in addition to Curschmann spirals and Laennec pearls. Sputum smear and culture may reveal normal or pathogenic flora. Immune globulin determinations often show increases in IgG and IgA levels in chronic asthmatics. Kaiser and Beall report that the second component of complement (C'_2) is generally elevated in patients with bronchial asthma.

Pulmonary Infiltration with Eosinophilia

There are several syndromes producing infiltration in the pulmonary parenchyma which have associated eosinophilia. These range from Loeffler's syndrome with transient migratory infiltration associated with high eosinophilia to periarteritis nodosa, a progressive arteritis with areas of infarction and necrosis accompanied by a modest eosinophilia.

Benign Loeffler's Syndrome

This syndrome consists of recurrent, transient, frequently migratory areas of pulmonary infiltration. It may be unilateral or bilateral. Benign Loeffler's syndrome frequently occurs in atopic individuals with a pre-existing diagnosis of asthma. Often, the patients are asymptomatic. Allergens are rarely demonstrated and parasites have not been found. Eosinophilia reaching 50 to 60 per cent has been present during the acute phase. Some observers believe that there are transient infiltrates or areas of atelectasis which develop with intermittent airway obstruction. Biopsies have demonstrated eosinophilic infiltrates in the interstitial tissue and mononuclear cell infiltrations of the alveolar exudate. Recovery is spontaneous. Steroids shorten the recovery time.

Chronic and Benign Loeffler's Syndrome

This syndrome has features almost identical to the benign syndrome. However, this type may persist as long as six months. Relapses are more common and the clinical picture is more severe. Biopsies have demonstrated eosinophils and giant cells along with interstitial fibrosis. Rarely, granulomatous lesions and necrotizing arteritis have been observed.

Antigen Related Loeffler's Syndrome

Mycotic lesions, including aspergillosis, coccidiomycosis and histoplasmosis, have simulated Loeffler's syndrome. Likewise, parasitic infestations are capable of producing pulmonary infiltrations and eosinophilia. The pulmonary changes tend to occur during the passage of the parasites (ie, ascarides) through the lungs during the larval phase of their life cycles.

Asthma with Intercurrent Pneumonia

Some patients with chronic asthma have a persistent eosinophilia. Occasionally, pneumonitis complicates their pulmonary picture. These infiltrates are fixed and respond to appropriate antibiotic therapy.

Tropical Eosinophilia

This syndrome is endemic in South America and Asia, particularly in India and Ceylon. The patients develop severe cough, wheezing and paroxysmal dyspnea. It is a relapsing disease and tends to become chronic. On chest roentgenogram, one frequently notes increased hilar infiltration with diffuse, mottled densities. Less often, soft confluent infiltrates are seen. The sputum may contain many eosinophils and there may be a 20 to 80 per cent peripheral eosinophilia. A high titer of cold agglutinins is common as is a positive Wassermann or Kahn test.

Parasitic infestations are found in about 50 per cent of these patients. However, specific anti-parasite therapy is ineffective. It is postulated that this is a condition of hypersensitivity to histamine. Its release is, perhaps, conditioned by the parasites. Effective therapy has been carried out with arsenicals in about 35 per cent of the cases.

Allergic Granulomatosis

This is a syndrome of recurrent episodes of pneumonia associated with moderate eosinophilia. In addition to eosinophilic and mononuclear cell infiltrate, there are areas of necrotizing angiitis and healing as well as extravascular granulomatous lesions. These lesions are not found in the upper respiratory tract. This syndrome is prone to develop in the terminal stages of chronic, severe asthma. Preceding bouts of Loeffler's syndrome are not uncommon.

Wegener's Granulomatosis

This syndrome consists of a triad of findings: (a) necrotizing granulomatosis of the upper respiratory

tract; (b) (focal) necrotizing vasculitis involving the arteries and veins, usually widely disseminated; and (c) focal glomerulonephritis. Klinger reported the first case in 1931 and Wegener described the features which distinguish this syndrome from other forms of angiitis. It has been regarded as a manifestation of abnormal immune mechanisms. Hyperglobulinemia is frequent. High fever, arthritis, and hemorrhagic lesions of the skin and mucous membranes may be prominent.

Wegener's granulomatosis is most prevalent in the fourth and fifth decades. The characteristic clinical triad consists of intractable rhinitis and sinusitis, nodular pulmonary infiltrates, and terminal uremia. The combination of granulomatous disease, plus vasculitis of the pulmonary arteries may result in pneumonitis, necrosis, cavitation, hemoptysis, and, infrequently, infarction. Giant cell infiltrate results in nodulation. Peripheral involvement may result in pleuritis.

Hypertension and eosinophilia are relatively rare. Allergic background is variable. Life expectancy is generally 7 to 12 months. In intermittent or subacute cases, survival may exceed two years. Death is usually due to renal failure.

Hypersensitivity Angiitis

This syndrome involves a diffuse, necrotizing vasculitis involving both small arteries and veins in addition to the larger pulmonary vasculature. The lesions are distinguishable from those of periarteritis, although the overall syndrome is similar. This syndrome follows the therapeutic administration of agents such as penicillin and sulfonamides. A more benign syndrome called allergic vasculitis also occurs which involves small arteries, veins and capillaries. A moderate eosinophilia is generally present in both syndromes. The vasculitis is usually accompanied by an intense cellular reaction of pleomorphic character and frequently containing eosinophils.

Periarteritis Nodosa

This necrotizing, inflammatory reaction of the vascular tree involves principally the smaller arteries or arterioles. All vascular coats are involved. Initial changes generally consist of necrosis and fibrinoid change in the inner media. As the intima thickens, thrombi tend to form and result in occlusion of the vessel with resultant infarction and cavitation. It is held that up to 29 per cent have pulmonary involvement. Also noted is the fact that, if pulmonary involvement is present, it is present from the outset. Lesions in the submucosal vessels of the trachea and bronchi may produce ulceration. A few cases have developed pulmonary cavitation. Necrotizing alveolitis has also been described. Biopsies have demonstrated numerous eosinophils in acute arteritic lesions. There are focal granulomatous lesions, unrelated to blood vessels, in the liver, spleen, kidneys, lymph nodes, and the heart.

Eosinophilia rarely exceeds 30 per cent, those with pulmonary lesions seeming to manifest the highest levels. Hemoptysis and pleural effusions are not uncommon. Clinically, the disease presents as asthma, bronchitis, or pneumonitis. There appears to be a relationship to pulmonary disease in early life, or chronic pulmonary disease, and periarteritis. Fifty to 80 per cent present as "intrinsic asthma." Roentgenogram findings are nonspecific. There may be migratory pulmonary infiltrates. Lesions may look like carcinomatosis, miliary tuberculosis, cavitation, abscesses, or pneumonitis. Serial x-rays are required to evaluate the patient adequately.

Sullivan and Miller have postulated that the respiratory tract is the site of entry of the antigenic stimulus in the greatest number of patients. Recently, a number of cases have been thought related to the therapeutic use of penicillin and sulfonamides in patients usually having allergic backgrounds. Autospecific antigen-antibody interaction has not been demonstrated in the vessel wall. Some postulate that circulating antigen-antibody complexes damage the vessel wall. Thus, they consider this the arthus type of humoral hypersensitivity. It has been found that about 28 per cent of the cases are associated with preceding respiratory infections and 8 per cent have active or quiescent rheumatoid arthritis while other cases are associated with rheumatic fever following streptococcal infections. Some cases have been associated with systemic lupus erythematosus.

Leys has postulated that genetically predisposed infants, when sensitized by contact with streptococci, develop an incomplete immunity. In later years, when autogenously or exogenously challenged, they react in different ways: (1) polyarthritis and the specific cellular reaction of the Aschoff body; (2) in the basal ganglia as chorea; (3) as localized tissue reaction in the capillaries, as in the Henoch-Schönlein complex, and possibly in the glomerular tufts as nephritis; (4) in the arterial wall as *periarteritis nodosa;* and (5) in the lung as rheumatic or rheumatoid pneumonia.

(To Be Concluded)

SELECTIVE CORONARY ANGIOGRAPHY does not induce persistent or significant hemodynamic abnormalities provided a serious arrhythmia does not supervene. — Alberto Benchimol, M. D., and Edward M. McNally, M. D., LaJolla, California: *The New England Journal of Medicine,* 274:1217-1224, June 2, 1966.

Endoscopy Revisited

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THE first attempts at peroral endoscopy were carried out by Phillip Bozzine (1807) and John Fisher (1925). Although admittedly somewhat crude, these efforts set in motion the impetus to develop endoscopy as we employ it today. Previous to the work of Gottstein (1891), endoscopy was attempted only under general anesthesia. Over the years our efforts have revolved 360 degrees with a return to a type of general anesthesia. During the interim, however, endoscopy has been conducted primarily under local anesthesia or to be more correct, topical anesthesia. We feel that the time has arrived when such practice should be re-evaluated and possibly discontinued. In our opinion, peroral endoscopy is best performed under total medication. We can see little value in the use of only a topical anesthetic and we decry the severe anxiety which such attempts produce in the patient. We would like, therefore, to set forth a simple, safe technique for all peroral endoscopy.

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Technique

The principle that must be grasped in this technique is that we are combining the salient features of topical and general anesthesia. The topical anesthesia negates the tracheobronchial reflexes and the intravenous medication produces general hypnosis without fear of apnea.

Preparation for peroral endoscopy correctly begins the evening before the scheduled procedure. Preoperative medication of adequate strength and duration of action is a prerequisite of the technique. The patient must approach the intended examination in a calm, tranquil state. Efforts to indicate what will be done and how it will be accomplished have been well rewarded. Such information greatly allays the patient's fears and many acquired misconceptions of the procedure.

An adequate sedative medication is given at the hour of sleep on the evening preceding the examination. Such medication is again repeated one and one-half hours before the scheduled endoscopy. If the intramuscular route is utilized, the time interval can be reduced. A combination of morphine sulfate in the amounts of 15 mg. combined with atropine sulfate in the amount of 0.4 mg. is given by hypodermic approximately one hour before the procedure. Previous to this, the patient has been held in a fasting state since the previous midnight. With such premedication, the patient arrives in the surgical suite in a calm state with adequate analgesia.

It is not essential that slavish attention to these specific medicants be observed. It is essential, however, that adequate medication of a similar type and strength be employed.

With the arrival of the patient in the operating room the topical anesthesia is carried out. Tetracaine (Pontocaine®) 2 per cent, in the amount of 2 to 4 cu.cm. is rapidly and adroitly injected transtracheally. A disposable 20 gauge needle with a 5 cu.cm. syringe attached is employed in this maneuver. While introduction of the needle through the cricothyroid cartilage (or triangle) is taught as the method of choice, we do not feel that this is essential. A simple penetration of the trachea at an intercartilaginous area will suffice. The spread of the medication is greatly facilitated if the injection is made immediately following an exhalation by the patient.

We hasten to point out that transtracheal anesthesia is not a new procedure. It was first described by George Canuyt and published by Labat almost 50 years ago. It was advocated for use in bronchoscopy by D. E. Harken and A. M. Salzberg in 1948 and has long been used by anesthesiologists as a simple means to facilitate intubation. The topical anesthesia thus produced becomes the second cornerstone of the technique.

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After the necessary equipment has been properly checked and all is in readiness, Pentothal® Sodium in 2.5 per cent solution is administered through the previously started intravenous infusion. At this point it is essential to understand that the Pentothal is utilized to produce only a light state of hypnosis. Excessive use of this drug or deletion of the topical and premedication agents will result in an undesirable anesthetic. The Pentothal is given to act synergistically with the local and premedication and cannot serve to substitute for them. It is essential that all three segments be fused at the moment of endoscopy. It will produce a safe, extremely satisfactory anesthetic without the danger of inadequate ventilation.

At the proper moment of sleep relaxation, the larynx or esophagus can be readily entered. In the instance of bronchoscopy, once the larynx has been entered, the patients airway is assured and any danger of inadequate ventilation is easily and readily controlled. In some cases, oxygen may be diffused through the side arm of the scope, if this type of bronchoscope is employed. We have found this addition of value in cases of pulmonary insufficiency from any cause. Oxygen may also be added in cases where the procedure is unduly prolonged as in teaching or biopsy endoscopies.

This method of anesthesia allows excellent relaxation for the viewing of the tracheobronchial tree, esophagus and upper gastric pouch. Only on very rare occasions have we found it necessary to place an endotracheal tube in the bronchus when doing esophageal endoscopy. The authors have found direct visualization of the upper lobe bronchi and their divisions to be a routine procedure. The use of lenses and mirror systems have been unnecessary and only add complications to a relatively simple procedure.

Following complete visualization of the tracheobronchial anatomy, a lavage with isotonic saline is carried out. The return is collected in a suction trap for examination by the laboratory. If the anesthetic level is correct, the cough reflex will be depressed but retained and thus will enable the collection of an adequate specimen from the minor bronchi. Additional topical anesthesia, bronchial dilating drugs and/or antibiotics may readily be administered in the lavage solution. An adequate biopsy, when desired, can be carried out. We make it a routine practice to take a biopsy specimen of the bronchial membrane for evaluation of its microscopic anatomy.

In addition to the patient's comfort, this technique allows the operator to further eliminate the traditional endoscopic legacies. The "headholder" can be readily dispensed with. Control of the patient's position on the table is easily carried out by moving the headrest and/or the table. The operator must guard against pressure on, or injury to, the mouth since pain from any source will arouse the subject and require additional anesthesia. The gentle manipulation of the head and neck is essential.

The second but more deadly legacy is that of the lightless room. We can find no reason for the traditionally darkened room to persist. Constant appraisal of the patient's condition is necessary and to accomplish this important task the anesthesiologist must be able to see his patient well and clearly. Today's standards of instrument illumination no longer necessitates this dangerous and outmoded darkness.

At the completion of the examination, the bronchoscope is withdrawn and an oral-pharyngeal airway is inserted. The patient is transferred to the recovery room. It has been our experience that a high percentage of these patients are awake by the time they are transported to the recovery room. We might also point out that, while topical anesthesia has depressed the cough reflex, it has not been completely obtunded. Hence these patients quickly regain their protective mechanism. Once the basic understanding of the cooperative action of the various anesthetic agents has been appreciated, the amount of Pentothal given will be minimal. We usually give between 200 and 300 milligrams of the drug and rarely use up to 500 milligrams. The procedure is appreciated by the patient and often is completed without his knowledge that the "dreaded" endoscopy has taken place. Our happiest patients are those that have had a previous endoscopy done under local anesthesia.

Results

During the preceding three years, nearly 2,000 peroral endoscopies have been successfully completed employing the method herein described. In this period, no complications attributable to the method of anesthesia has been encountered. Acceptance by the hospital surgical personnel has been complete. Appreciation shown by the patients has been gratifying. Acquisition of the necessary information and specimen by the operators have been most satisfactory in all respects. Therefore, we feel that peroral endoscopy performed under this type of combined anesthesia to be superior in all respects. Continued use of topical anesthesia alone, with the obvious disregard of the patient's discomfort, needs to be seriously questioned. Employment of darkened surroundings should be discontinued in the best interest of all concerned. We do not indicate that this method of endoscopy is superior to all others, however, we strongly feel that it is a marked improvement over what has become common practice.

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Intracranial Aneurysm

A Nine-Year Study

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RUPTURE of intracranial aneurysms due to congenital weakness in the vessels of the circle of Willis is a significant cause of death and disability in young and middle-aged adults.[1] Because of this high mortality,[2] it is important to identify intracranial aneurysms early so that measures to prevent further or fatal hemorrhage can be instituted.

The diagnosis of unruptured aneurysm is only occasionally possible. Unruptured aneurysms were found in only 6 per cent of this series. Three per cent appeared with optic or abducens nerve deficits. One and one-half per cent presented with a third cranial nerve palsy. One and one-half per cent appeared with headache considered significantly focal to warrant angiography. The appearance of such cranial nerve palsies, or of fixed retrobulbar headache, is an indication for angiography.

Aneurysms usually show their presence by an acute subarachnoid or intracerebral hemorrhage. Most observers have reported a mortality of 44 to 70 per cent in patients not subjected to surgical treatment.[2] Our mortality in operated and nonoperated cases of intracranial aneurysm is 38 per cent.

Little can be done if the hemorrhage does not stop spontaneously. If bleeding stops, the first goal of treatment is to minimize the likelihood of rebleeding while the patient is recovering from the effects of the first episode. Surgical treatment, based upon accurate angiography, is then planned to eliminate the danger of further bleeding. As will be shown, the surgical risk is low in patients who have not sustained serious brain damage as a result of the first hemorrhage, or who recover from the effects of that hemorrhage (Table 2).

The physician, therefore, must be aware of the significance of instantaneous onset of headache, followed by nuchal rigidity. If the hemorrhage is of brief duration, the headache may not be severe, or may be delayed for as long as 24 hours. The danger of recurrent hemorrhage is greater in these cases than in the more easily diagnosed cases in which coma and neurologic deficits are present.

Bloody spinal fluid with a yellow supernatant layer is diagnostic of subarachnoid hemorrhage. Angiography should be performed as soon as it appears that the patient will survive the first hemorrhage and that definitive treatment to prevent further bleeding may be possible.

There is a strong correlation,[3,4] between the patient's clinical status and the surgical morbidity and mortality (Tables 1 and 2). We have graded this series by Botterel's method[5]:

Grade I	Asymptomatic, or minimal headache and slight nuchal rigidity.
Grade II	Moderate to severe headache, nuchal rigidity without neurologic deficit.
Grade III	Drowsiness, confusion, or mild focal deficit.
Grade IV	Stupor, moderate to severe hemiparesis, possibly early decerebrate rigidity and vegetative disturbances.
Grade V	Deep coma, decerebrate rigidity, moribund appearance.

Coexistent hypertension, diabetes, severe arteriosclerosis, uremia, or chronic pulmonary disease affect the prognosis unfavorably in all grades.

TABLE 1. *Aneurysms at Admission*

Grade	Number	Deaths	% Mortality Rate
I	33	5	15
II	51	12	23
III	37	20	54
IV	15	12	80
V	4	4	100
	140	53	38

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From the Department of Surgery, Division of Neurological Surgery, The Ohio State University College of Medicine, Columbus, Ohio. Submitted July 1, 1966.

TABLE 2. *Intracranial Aneurysmorrhaphy*

Grade	Number	Deaths	% Mortality Rate
I	49	2	4
II	23	3	13
III	11	3	27
IV	7	4	57
V	3	3	100
	93	15	16

By our criteria, mild subarachnoid hemorrhage demands immediate diagnosis and treatment, whereas a period of supportive care is indicated after severe hemorrhage. Figure 1 shows a posterior communicating artery aneurysm with spasm of the adjacent arteries. Such spasm seems to play a major role in the production of neurologic deficit after subarachnoid hemorrhages. Figure 2 shows the same arterial tree ten days after clip ligation of the aneurysm.



FIG. 1. *Posterior communicating artery aneurysm. Severe middle cerebral artery spasm.*

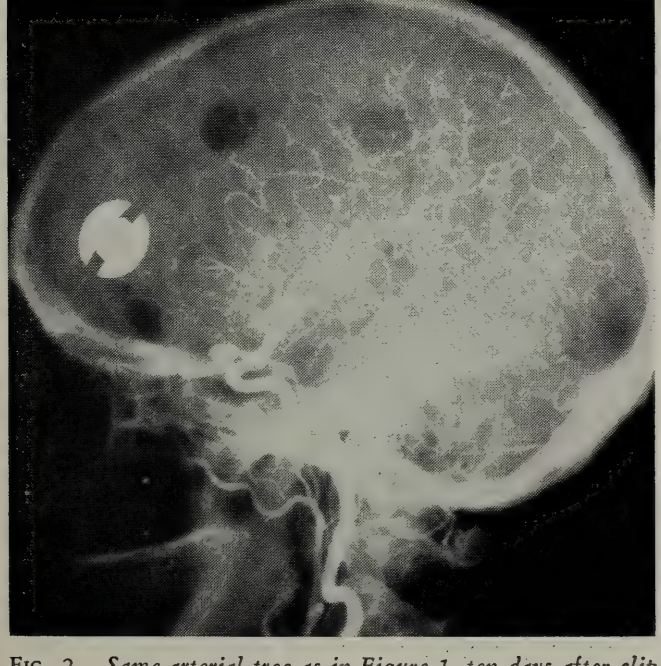


FIG. 2. *Same arterial tree as in Figure 1, ten days after clip ligation of the aneurysm. No spasm present.*

We have reviewed the 235 cases of subarachnoid hemorrhage or aneurysms without hemorrhage admitted between January 1, 1954 and March 1, 1963 (Fig. 3, Chart 1). All cases have been documented by either angiographic, operative, or necropsy findings. The series has been analyzed by recording 40 items of pertinent data for each patient.

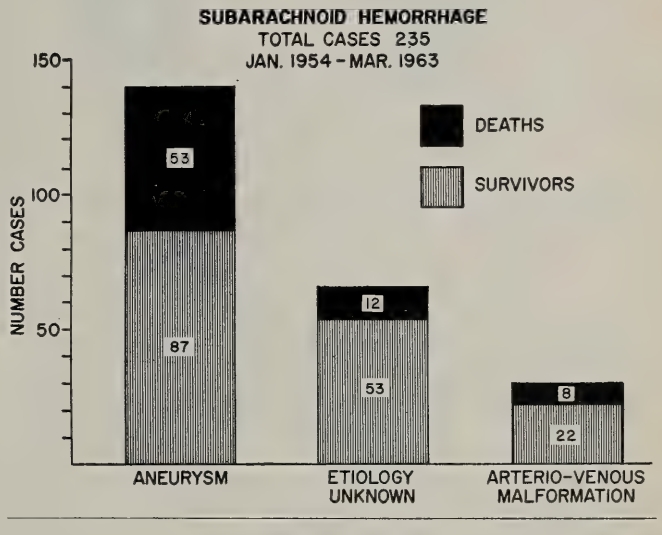


FIGURE 3 *(Chart 1)*

A previous review of our series was completed in 1961. At that time we had treated 91 aneurysms with a survival rate of 59 per cent.[4]

In the present series, 62 per cent, or 87 of 140 patients with aneurysm survived. By contrast, 72 per cent, or 53 of 65 patients with subarachnoid hemorrhage without demonstrable etiology survived, as did 73 per cent, or 22 of 30 patients with arteriovenous malformations.

The overall mortality rate for subarachnoid hemorrhage, regardless of cause, is 31 per cent; the rate with aneurysm alone is 38 per cent. This series is unselected and includes moribund patients who died soon after admission and were shown at autopsy to have ruptured intracranial aneurysms.

Of the 140 aneurysms, 103 had surgery; 37 did not. Figure 4, Chart 2 shows an 82 per cent survival rate in the operated group, and an 8 per cent survival rate in the nonoperated group.

There is evidence that the danger of recurrent bleeding is greatest in the first few days following the initial rupture. We have found that the lower the grade, i.e., the better the patient, the greater the risk of rebleeding. Table 1 shows the mortality rate by grade at admission, and Table 2 shows the rate by grade at the time of intracranial surgery. The con-

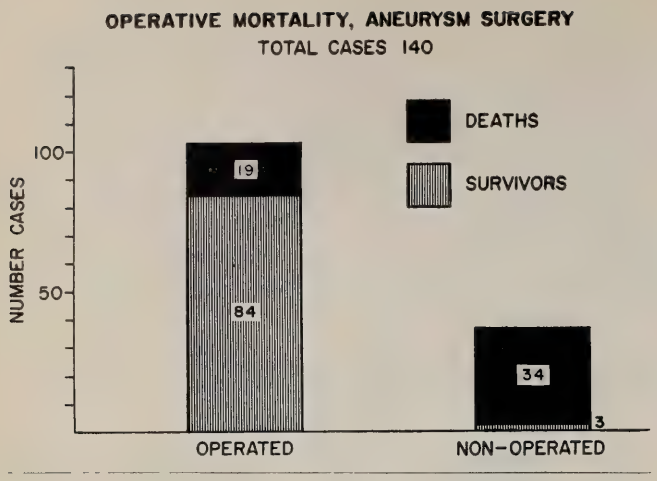


FIGURE 4 *(Chart 2)*

spicuous difference in mortality rates will be analyzed with our results.

Cervical Carotid Ligation

Table 3 shows the results of cervical carotid ligation.

TABLE 3. *Direct Intracranial Ligation vs. Cervical Carotid Artery Ligation*

	Number	Deaths	% Mortality
Direct Ligation	93	15	16
Carotid Ligation	10	4	40
	103	19	18

In three additional cases, cervical carotid ligation has been performed since March 1, 1963. Two have been successful; the other patient died of infarction of the hemisphere and massive cerebral edema.

Our opinion is that cervical carotid ligation, except in selected cases, is not as satisfactory as the intracranial approach. The risk of rebleeding after ligation still exists. Mortality has been 38 per cent. Nonfatal complications include two patients with hemiplegia and aphasia.

Ninety-three patients had intracranial ligation or aneurysm strengthening procedures. The operative mortality for Grades I and II was 7 per cent. There were five deaths of which four must be put down to technical failures. In two patients, the clip became dislodged and rebleeding resulted. A postoperative epidural hematoma caused another death. One patient died of cerebral infarction attributed to vasospasm, and perhaps should have been graded III instead of II. The fifth death was caused by overwhelming postoperative pneumonia.

Results in Grades I and II

Because the overall mortality (Table 1) was so much greater than the surgical mortality (Table 2) in Grades I and II, these cases were subjected to intensive review. Tables 1 and 2 show that 84 such patients were admitted. Seventy-two were operated upon and five died, a mortality of 7 per cent. Twelve patients not operated upon also died. The overall mortality in patients graded I and II was thus 20 per cent. Eight deaths were adjudged preventable. There were three avoidable delays in diagnosis, two failures to perform vertebral arteriography, one ill-advised cervical carotid ligation, one postoperative epidural hematoma, and one error in patient classification. Nine deaths were adjudged nonpreventable. Six patients died from rapid rebleeding. One had rebleeding after cervical carotid ligation. One had cerebral infarction after cervical ligation. Another had ligation of multiple aneurysms but postoperative cerebral infarcts occurred from severe cerebral arteriosclerosis. Clearly the danger of early rebleeding is present in patients classified Grade I or Grade II at the time of admission.

Results in Grade III

Because of the high mortality (54 per cent) in cases considered Grade III at admission, this group was reviewed to determine whether the policy of delayed intervention was justified (Table 4).

TABLE 4. *Analysis of Grade III Patients on Admission*

SURVIVORS 17	6	Operated at Grade I
	7	" " " II
	2	" " " III
	1	" " " IV
	1	Not Operated
DEATHS 20	1	Operated at Grade I
	3	" " " II
	2	" " " III
	1	" " " IV
	13	Not Operated

Of the deaths, 13 patients were not operated; seven of these died in deepening stupor without rebleeding. Four patients had rapid rebleeding less than 24 hours after admission. One had a vertebral basilar aneurysm and died awaiting definitive treatment. Another probably rebled from an unrecognized aneurysm at the basilar termination. We do not think that any of these nonoperative deaths could have been salvaged.

Analysis of deaths of Grade III patients at admission showed that seven were operated. One had surgery at Grade I and died because of technical failure. Three were operated at Grade II and in this classification, two were craniotomies and one a cervical carotid ligation. Two were operated at Grade III. One was operated early in the series at Grade IV as a measure of desperation.

Table 4 shows 17 survivors who were Grade III upon admission. Thirteen improved with conservative therapy to Grades I and II, and two were operated at Grade III. One was operated at Grade IV (evacuation of temporal lobe hematoma), and subsequent arteriography showed the aneurysm and parent vessel obliterated. One patient was not operated and survived in a vegetative state without evidence of rebleeding.

In this group, then, the risk with immediate operation is high, the risk of rebleeding is low, and much

of the mortality is related to cerebral infarction, not to secondary hemorrhage.

Morbidity

In 26 patients having either intracranial ligation or cervical carotid ligation, eight were seriously handicapped with aphasia, hemiplegia, psychosis, or prolonged coma. One half of the patients with serious morbidity had had cervical carotid ligation. Eighteen patients had had minor deficits such as dysphasia, hemiparesis, cranial nerve palsy, mild intellectual defect, or temporarily reduced visual acuity.

Summary

It is our policy to treat proved aneurysm by intracranial operation whenever possible, employing ligation of the neck of the aneurysm or external reinforcement of the sac. Trapping procedures or ligation of the cervical carotid artery may be considered when direct attack is not possible. Cervical carotid ligation has not been totally satisfactory in our hands because of the incidence of rebleeding or infarction. Our mortality for this procedure is 40 per cent. Our recommendation is that its use should be confined to instances where direct attack is patently impossible. We advocate craniotomy without delay in Grades I and II because our experience shows that the risk of early rebleeding is great in these groups. No patients were lost in the last 24 months of this survey because of diagnostic delay.

By contrast, in Grades III, IV, and V, the risk of rebleeding is less, and the danger of surgery is greater. These patients are not subjected to immediate operation until they improve to a better grade. The risk inherent in this policy is that a certain number of patients may be lost from rebleeding during the waiting period. However, most of the mortality is from causes that cannot be prevented by early surgery, and the operative risk is much less after the patient has improved. Therefore, unless repeated bleeding occurs, a period of conservative therapy seems justified. Our statistics support the thesis that patients in this group survived who would have been lost had they been operated upon earlier.

As a rule, patients graded at IV and V upon admission cannot be helped by surgery. Our mortality with Grades IV and V has been 80 and 100 per cent respectively.

The exception to the policy of delayed surgery in Grades III through V is that a large intracerebral hematoma, threatening life, should be evacuated. Definitive repair of the aneurysm may be postponed to avoid manipulating vessels in spasm.

Conclusions

1. Intracranial obliteration of aneurysms to prevent further hemorrhage is indicated whenever possible.
2. Surgical risk is low in patients who are in good condition at the time of operation.
3. Surgical risk is related to signs of meningeal irritation and neurologic deficit.
4. Surgical intervention is urgent in patients admitted in good condition, but delay of operation until patient's condition improves is justifiable in the more seriously ill.
5. Progressive encephalopathy, presumably due to vasospasm and ischemia, is a more common cause of death than is recurrent hemorrhage in the poor risk patient.
6. Cervical carotid ligation should be reserved for cases in which direct attack is not practicable.

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A RUPTURED ANEURYSM of the anterior communicating artery usually is manifested only by the headache characteristic of intracranial subarachnoid hemorrhage. Probably these patients more consistently localize the initial pain in the "front of the head" or "behind the eyes," but more often the initial complaint is simply an extremely severe headache.

Of the more common intracranial aneurysms, those of the anterior communicating artery least often produce a lateralizing neurologic deficit upon rupturing. An aneurysm of the anterior communicating artery may bleed into the substance of the adjacent cerebral hemisphere as well as into the subarachnoid space. Thus, such aneurysms, upon rupturing, may cause loss of consciousness more often than those at other sites.

Although aneurysms of the anterior communicating artery are close to the optic chiasm, they rarely cause a visual deficit. It has been observed, however, that hemorrhage from these aneurysms seems more likely to extend along the optic nerves and be seen as small collections of blood in the optic fundus. — Homer D. Kirgis, M. D., Ph. D., John D. Jackson, M. D., William L. Fisher, M. D., and Edward McC. Peebles, Ph. D., New Orleans: Aneurysms of of the Anterior Communicating Artery, *Southern Medical Journal,* 59:753-759, July 1966.

Subdural Hematoma in Posterior Fossa

Report of a Case Complicated by Meningitis in a Newborn Infant

C. NORMAN SHEALY, M. D.

POSTERIOR FOSSA subdural hematomas are rare lesions which should have a good prognosis if treated early. Recently we encountered an unusual example of this entity complicated by neonatal meningitis in a newborn infant.

Case Report

This 4 day old boy was transferred to Babies and Childrens Hospital because of a bulging fontanel and a single generalized seizure. Pregnancy had been complicated by excessive weight gain and some bleeding in the last trimester. Labor was unremarkable, but the child was noted to have a hematoma on the right side of his face at birth. On the third day of life the fontanel was noted to be quite full.

Physical Examination: The child's length was 53 cm; weight 3.2 kilograms; and head circumference 38 cm. There was no significant residual sign of birth trauma. The fontanel was bulging and quite firm and the sutures were separated. He was generally hypotonic with respirations ranging between 15 and 40 per minute and pulse ranging between 80 and 120/minute. Fundi were unremarkable. Moro reflex was very poor, and suck was fair at best. His cry was very high pitched.

Laboratory Data: Hematocrit was 32 per cent; white blood cell count 16,500; differential shifted to the left; bilirubin 12.2 mg per 100 ml total; blood sugar 147 mg per 100 ml; prothrombin time 34 per cent; and platelets 158,000.

Course in Hospital: Shortly after admission bilateral subdural taps were done and these were negative. After the child was given whole blood, a ventricular tap revealed slightly yellow ventricular fluid, which was loaded with bacteria on microscopic examination and which contained 12 white cells/cu.mm.; protein 154 mg/100 ml; sugar 7 mg/100 ml. Cultures grew *Escherichia coli.* Air study revealed that there was a complete block at the posterior third ventricle and moderate hydrocephalus. He was treated with chloramphenicol and tetracycline and received intraventricular polymyxin B for three days. Although the ventricular fluid became sterile, it continued to run a low sugar and up to 100 white cells/cu.mm. He required ventricular taps every two to three days because of pressure, but generally he was eating well, became afebrile, and began to gain some weight. A right retrobrachial arteriogram demonstrated only hydrocephalus.

Repeat ventriculogram revealed forward displacement of the aqueduct which was confirmed by a Pantopaque® ventriculogram (Fig. 1). However, the ventricular system remained midline. The possibility of posterior fossa abscess was strongly considered, but because of the child's very poor condition, posterior fossa exploration was not performed and a ventriculoperitoneal shunt was planned. However, on September 29, 1964 he developed seizures and became obtunded. Ventricular tap revealed the fluid to be very hazy whereas it had been clear previously. There were 1200 white cells/cu.mm.; 69 per cent monocytes; 31 per cent polymorphonuclear cells; sugar 4 mg/100 ml; and protein 400 mg/100 ml in the spinal fluid. The child rapidly deteriorated and died on September 29, 1964.

Autopsy revealed mild meningitis, moderate hydrocephalus, and a large subdural hematoma of the posterior fossa extending through the tentorial notch to the torcular.

Discussion

Extradural and subdural hematomas of the posterior fossa are rare lesions. Most reports have consisted of single cases which have followed external trauma.[1-3] The period between injury and diagnosis ranged from a few hours to five months and symptoms of these lesions are the nonlocalizing ones of posterior fossa mass lesion. Birth trauma with mild subarach-



FIG. 1. *Pantopaque ventriculogram, demonstrating hydrocephalus and anteriorly displaced fourth ventricle and aqueduct.*

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Submitted March 21, 1966.

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noid hemorrhage is relatively common and lacerations of the torcular or other sinuses are seen not infrequently. Nevertheless, a sizeable hematoma in such a situation is a rare finding.

More commonly these birth lesions are associated with widespread cerebral bruising. Some authors believe that most communicating hydrocephalus develops from posthemorrhage arachnoiditis. Neonatal meningitis is also a rarity and the coexistence of these two entities has not been previously reported.

The patient presented here was never in satisfactory physical condition to allow consideration of surgery and it seems unlikely that evacuation of the hematoma would have been successful. Relapsing meningitis should always lead to suspicion of mass lesion and this case demonstrated additionally that any block to cerebrospinal flow can produce stasis preventing antibiotic sterilization, even when the organism is sensitive.

Summary

This report concerns a newborn infant with relapsing meningitis, hydrocephalus, and a posterior fossa subdural hematoma due to a tear of the torcular. The latter lesion should be suspected in infants who rapidly develop hydrocephalus. Successful therapy must depend upon prompt diagnosis.

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CHRONIC SUBDURAL HEMATOMA may simulate intracerebral hemorrhage. In such patients, somnolence or unconsciousness for prolonged periods alternates with periods of alertness.

The patient whose condition is diagnosed as cerebral hemorrhage who has coma persisting longer than twenty-four hours is doomed to a fatal termination, but his life may be saved if burr holes, arteriography, or air studies reveal a subdural hematoma or other space-occupying lesion. If such studies do not reveal a removable lesion, evacuation of the intracerebral clot may save a life. — Abraham M. Rabiner, M. D., Brooklyn, N. Y.: *New York State Journal of Medicine,* 66:947-950, April 15, 1966.

CARING FOR THE PATIENT. — The physician of fifty years ago had, in many situations, only himself to offer, and though incomparably less effective in terminating certain diseases, notably the infections, he knew how to throw his weight into the balance on the patient's side. There is nothing in today's advances that need prevent us from emulating him.

The statement that "we should not treat diseases but people" is often quoted and much more often disregarded. When one tells students and house officers, "At times what you say to patients is more important than what you do for them, and it may be more damaging to say the wrong thing than to give the wrong medication," one is telling a truth that all practicing physicians have had to learn.

Success in this important phase of therapy is the result of the development of a real golden-rule policy by the physician. When he has developed the essential habit of trying to find out just what the patient is feeling and fearing — in other words to imagine himself in the patient's situation, anxieties and worries included — he will be able to avoid everything disturbing and to build up the patient's morale. As Charcot said, "The best inspirer of hope is the best physician." — Alex M. Burgess, M. D., Providence, R. I., and Alex M. Burgess, Jr., M. D., Boston: *The New England Journal of Medicine,* 274:1241-1244, June 2, 1966.

Aneurysmal Bone Cyst Of the Calvarium

Report of a Case with Isotopic Visualization

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and LEON L. BERNSTEIN, M.D.

ANEURYSMAL bone cyst is not a common lesion, constituting about 1 per cent of all bone tumors according to Guy, et al.[5] They are not regarded generally as true neoplasms and rarely have they been known to undergo neoplastic change, despite the fact that they may become massive in size. One case has been reported in which a fibrosarcoma developed at the site of an aneurysmal bone cyst subjected to intense radiation on the mistaken premise that it was a giant cell tumor.[9] Lichtenstein[8,9] believes that they are the result of some persistent local alteration in hemodynamics, such as a venous thrombosis or arteriovenous fistula, leading to the development of a dilated and engorged vascular bed. This concept is accepted by most writers, although recently Edling[4] has proposed the name of subperiosteal dysfibroplasia, considering these lesions to be one of the manifestations of dysfibroplasia of bone.

About three fourths of aneurysmal bone cysts involve the shaft of a long bone or some part of the vertebral column,[10] although they have been reported in the clavicle, ribs, scapula, and small tubular bones of the hands and feet, occurring in the skull most infrequently. The present report is of the occurrence of an aneurysmal bone cyst in the frontal bone, this case incidentally being the first in which localized uptake by a radioactive isotope was demonstrated.

Case Report

The patient was a 21 year old woman seen in November, 1963, with the complaint of a "lump" in the frontal region. There was a history that about nine years previously she had been struck in the right frontal area with a golf ball. Following this, a local swelling developed which never completely disappeared although it remained otherwise asymptomatic. About five weeks prior to examination, progressive enlargement began, this being associated with an increasingly severe, dull frontal headache. Three weeks before examination, the mass became soft, described by the patient as feeling as if it had "fluid in it." The headache was confined to the right frontal and adjacent parietal area with occasional discomfort about the right eye, but without visual disturbance. On examination the significant findings were related to the local lesion. The tumor was in the right frontal area immediately behind the hairline, was not particularly tender, did not pulsate and had no bruit. The tumor mass, while soft, was not fluctuant and measured about 4 cm. in diameter. Neurologic examination was otherwise normal.

Roentgenographic examination revealed a 3.5 cm. lytic lesion in the right frontal bone. The margins of the lesion were scalloped but fairly well maintained, some areas showing mild sclerosis. A few remnants of bone spicules could be identified but septae could not be seen (Fig. 1-A). Tangential views demonstrated thinning of the bone edges and in some areas a very narrow subperiosteal rim of bone remained (Fig. 1-B).

A brain scan employing 804 microcuries of Hg^{203} revealed an abnormal concentration of the isotope coinciding with the tumor mass in the right frontal bone (Fig. 2).

At operation the reflected scalp revealed the tumor mass to have a bluish-grey, fibrous wall. When this was incised, a cavity containing old blood and some yellow fluid was disclosed. Evacuation of the contents exposed a trabecular inner wall containing a few spicules of bone with some adherent tissue. Frozen section showed osseous tissue with fibroblastic proliferation. Block excision was done, the tumor being only loosely adherent to the underlying dura. The floor of the bony cavity was extremely thin to the point where a flat instrument passed between it and the dura could be seen through the bony layer. The cystic cavity measured 1.5 cm. in depth and, where the bone was intact, small dark areas, having the appearance of dilated vessels, could be seen (Fig. 3-A).

Microscopically the inner table showed small spicules of cancellous bone undergoing resorption and areas where new bone stroma was being formed (Fig. 3-B). The lining of the large cystic cavity was composed of a cellular stroma of long fusiform cells and a scattering of large, multinucleated, syncytial giant cells. There were numerous, large, thin-walled, tortuous, vascular spaces separated by fibrous strands. Many of these spaces contained blood whereas others were empty.

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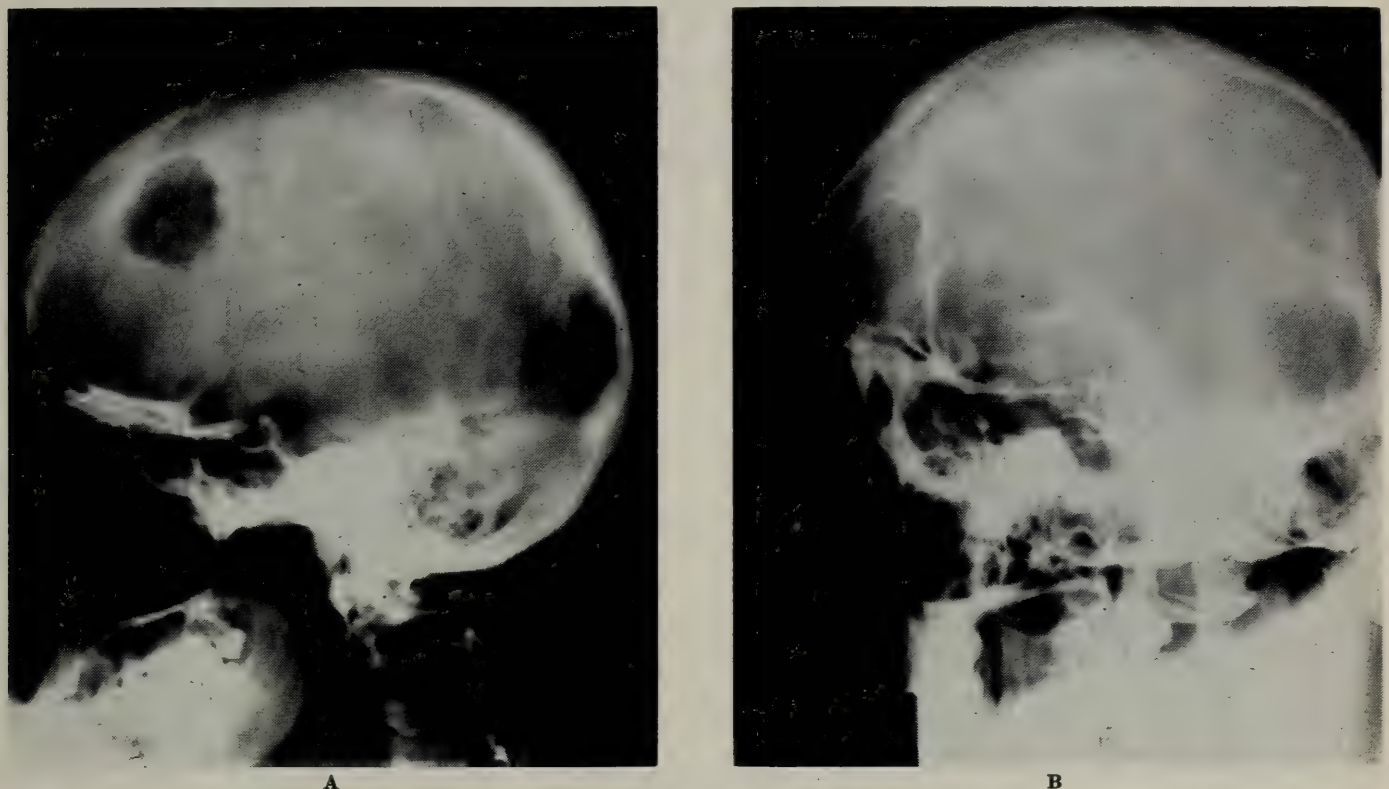
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Submitted April 13, 1966.

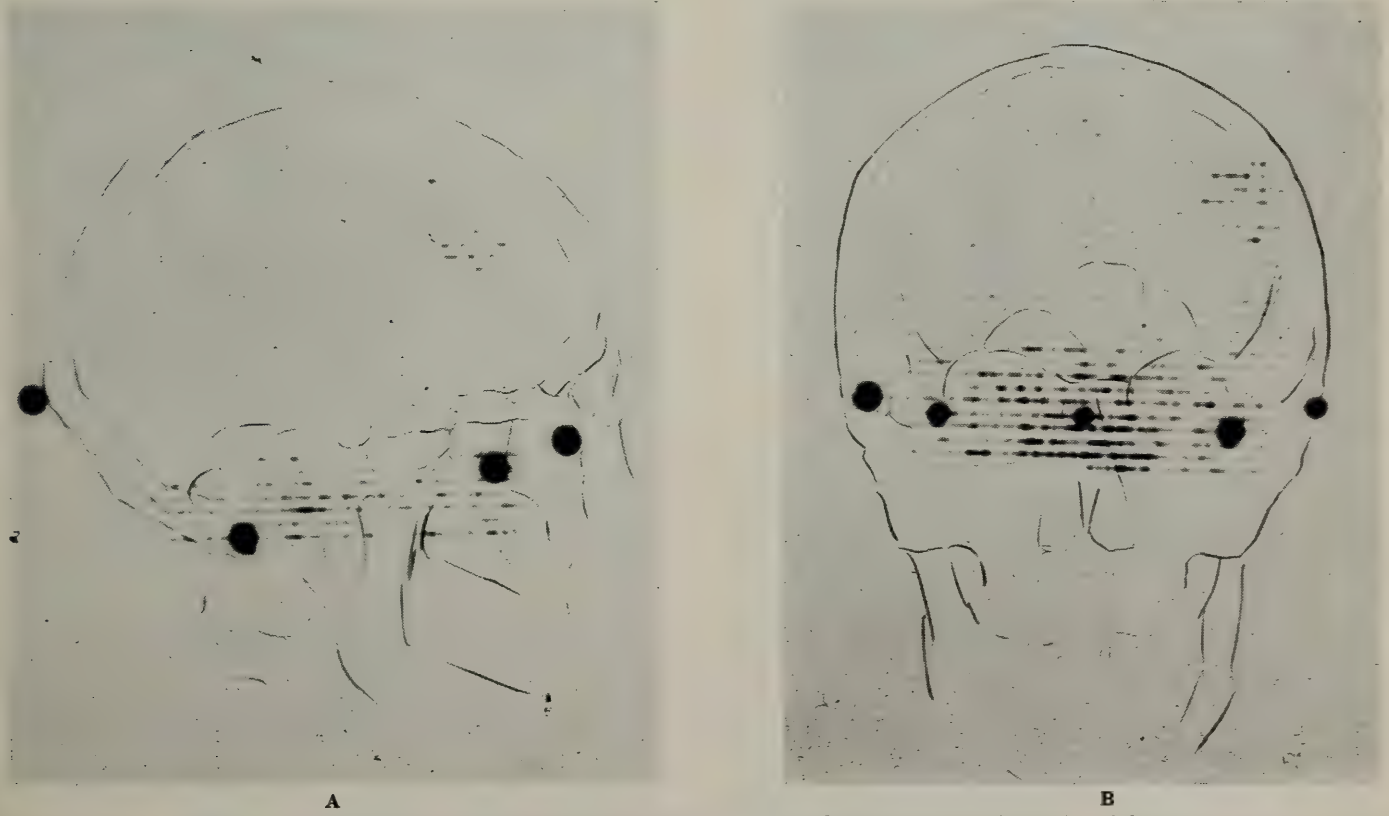
Discussion

A review of the considerable literature which has appeared in the past ten years since aneurysmal bone cyst was defined as a clinical entity by the work of Lichtenstein[8] and of Jaffe[6] indicates that there has been little reference to its appearance in the bones of the calvarium. Of Lichtenstein's[8] 17 cases, the skull was involved in only one instance, this being in the occipital bone. In the 26 cases reported by Dahlin, et al.,[3] one occipital lesion was mentioned. Cruz and Coley[2] reported 20 cases and Sherman and Soong[11] 43 cases with no involvement of the skull. Jeremiah[7] has reported surgical removal of a large aneurysmal bone cyst of the temporal region in a



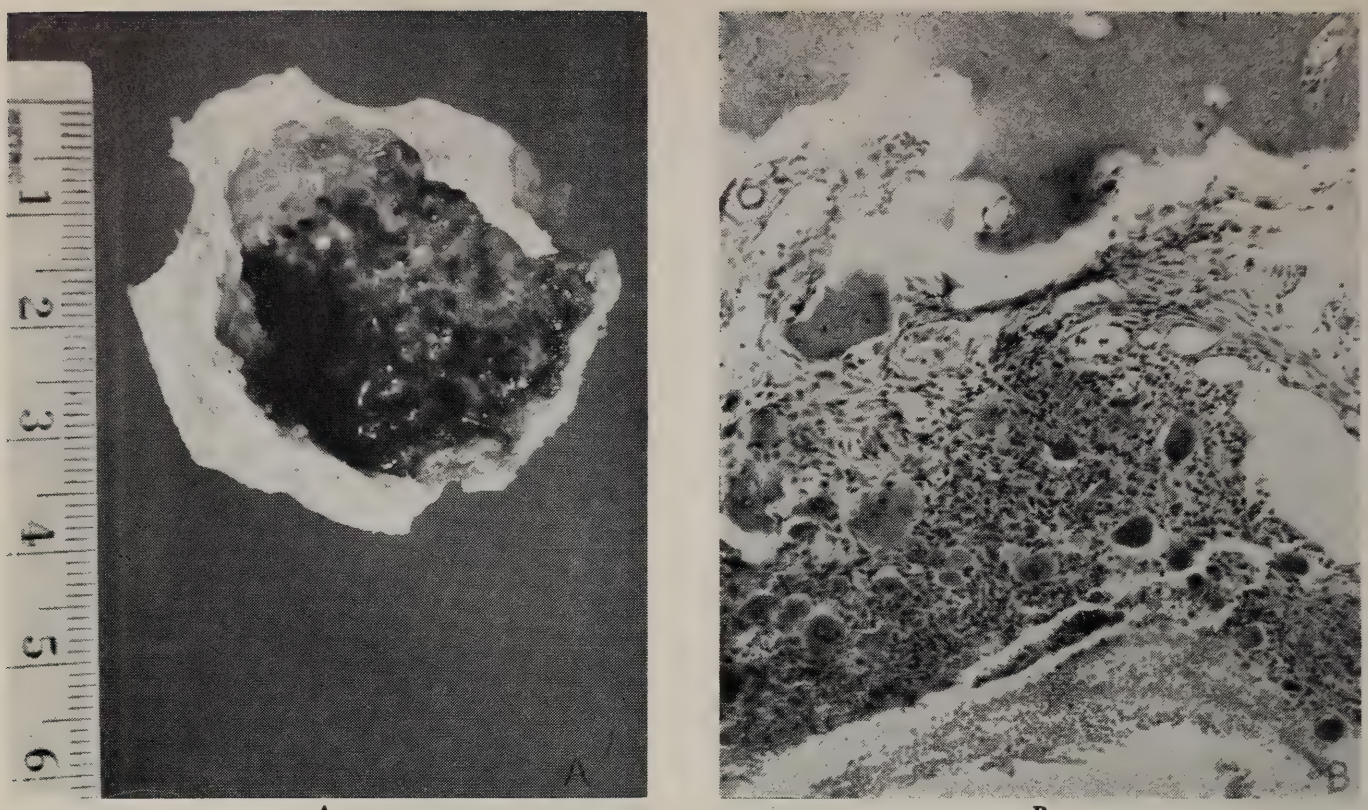
A B

FIG. 1. **(A)**. *Roentgenogram of skull showing scalloped margins and remnants of bone spicules.* **(B)**. *Tangential view showing expanding character of lesion and thinning of bone.*



A B

FIG. 2. *Lateral* **(A)** *and frontal* **(B)** Hg^{203} *brain scan showing increased uptake of lesion.*



A B

FIG. 3. **(A)**. *Gross illustration showing cavity of cystic lesion.* **(B)**. *Photomicrograph illustrating vascular spaces, giant cells, fibrous stroma and bone spicules.*

24 year old woman, who four months previously had subtotal excision done with the diagnosis of giant cell tumor. Lichtenstein[9] has more recently reported his observations on 50 cases and mentions three occurring in the skull.

The relationship of trauma to the aneurysmal bone cyst is not clear, most authors tending to discount it as a causative factor but accepting trauma as a possible aggravating circumstance. In the five cases reported by Phelan[10] two patients mentioned trauma as a possible precipitating element. Guy, et al.,[5] in reviewing 66 recorded cases, found a positive history of trauma in about 50 per cent, while Cruz and Coley[2] quote Thompson[12] as reporting a history of trauma in 61 per cent of the cases in the literature. At the same time these authors express the view that trauma plays no role other than to call attention to a preexisting lesion.

In the present case there was an apparent relationship between the first appearance of the lesion and local injury. If one rejects Cone's[1] concept of the lesion as an excessive reparative process secondary to a traumatic subperiosteal hematoma, it is still quite possible that trauma may in some instances initiate the local circulatory disturbance referred to by Lichtenstein.

The radiologic picture in the present case was fairly characteristic except that at the time the patient was seen the bone destruction had progressed to the stage where ridges or septae were not prominently visible. To the writer's knowledge, this is the first reported instance in which this type of lesion has been visualized by isotopic scan, the selective uptake of the isotope not being unexpected in view of the vascular nature of the lesion.

Summary

A case of aneurysmal bone cyst of the right frontal bone has been reported in which trauma appeared to have been an initiating factor. Selective uptake by Hg^{203} has been demonstrated. The literature relative to involvement of the calvarium by this lesion has been briefly reviewed.

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A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

Presented by

- **Norton J. Greenberger, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus;**

Edited by Dr. von Haam.

PRESENTATION OF CASE

First Admission: Eight years prior to the final (third) admission, this 65 year old white man was admitted to University Hospital with a history of painless hematuria for the past three months. A well differentiated transitional cell carcinoma of the bladder was resected, and the patient apparently did well until his second University Hospital admission two months prior to his final admission.

Second Admission

The patient noted the onset of weakness, easy fatigability, and anorexia four months prior to the second hospital admission, with a weight loss of 15 lbs. A blood count done six weeks prior to this admission revealed anemia and he was started on oral iron therapy. On the day prior to admission he had an episode of hematemesis followed by melena. He denied previous melena or hematemesis, pyrosis, food intolerance, nausea or vomiting. He had no previous history of icterus or hepatitis or any episodes of pruritus. He had received no blood transfusions. He had once been examined at the Mayo Clinic because of multiple subcutaneous nodules that had been present for 20 to 25 years.

Physical examination revealed a chronically ill appearing white man. The vital signs were normal. On the extremities and trunk were multiple, freely movable, nontender, subcutaneous nodules of various sizes. No areas of hyperpigmentation or spiders were noted. The sclerae were slightly icteric; the fundi appeared normal. No lymphadenopathy was noted. The lungs were clear. The heart was not enlarged; the rhythm was regular. A grade II/VI apical systolic ejection murmur was heard. The abdomen was not distended; the upper right quadrant was slightly tender. The liver was palpable 6 cm. below the right costal margin and was nontender. The spleen was not palpable, nor were any abdominal masses. A tarry, guaiac-positive stool was found on rectal examination. There was no edema of the extremities. The neurological examination revealed no abnormalities.

Laboratory examinations revealed a hemoglobin of 9.6 Gm., hematocrit of 29 per cent, 5,000 white blood cells with a normal differential count. The urine was not remarkable. The serum sodium was 138, the potassium 4.8, chlorides 113, and CO_2 combining power 26 mEq./liter. The blood urea nitrogen (BUN) was 27, the creatinine 0.8 mg./100 ml. The inorganic phosphorus was 2.8 mg./100 ml.; alkaline phosphatase 11.9 Shinowara-Jones-Reinhart units; serum cholesterol 187 mg./100 ml. with 67 per cent esterification; total bilirubin 4.2 mg./100 ml. with 1.8 mg. direct-reacting bilirubin; cephalin flocculation 2 plus; thymol 60 mg./100 ml.; total protein 6.0 Gm./100 ml. (albumin 3.1, globulin 2.9); bromsulphalein 30.7 per cent; prothrombin time 40 per cent; the serum glutamic oxalacetic transaminase (SGOT) was 59 units, the glutamic pyruvic transaminase (SGPT) 19 units, and the lactic dehydrogenase (LDH) 472 units.

The electrocardiogram was within normal limits. On chest x-ray the heart and lungs were within normal limits. An upper gastrointestinal film showed esophageal varices, cholelithiasis, and splenomegaly. The intravenous pyelogram and the barium enema showed no abnormalities.

A nasogastric tube was inserted and clear fluid was aspirated. Over the first 36 hours he received 4 units of whole blood; his hemoglobin rose to 11-12 Gm. and stabilized at that level. He gained weight and developed ascites. On paracentesis a clear yellow fluid was obtained which had a specific gravity of 1.002, an amylase of 7 units, and a class II Papanicolaou smear reading.

The patient was then given diuretics and during his 20 day hospital stay responded with a 12 lb. weight loss on sodium restriction, chlorothiazide, and Aldactone®. He was also treated with multivitamins and Mephyton®. The prothrombin time increased to

Submitted August 17, 1966.

65 per cent. The total bilirubin dropped to 1.4 mg. A percutaneous liver biopsy was considered unsatisfactory for accurate pathologic diagnosis but was interpreted as essentially normal. On splenoportogram a pressure of 420 mm. of water was obtained. A retrograde flow through the inferior mesenteric vein and also through a large coronary vein with fundo-esophageal varices was demonstrated. No evidence of thrombi in the splenic or portal venous system was seen. After a surgical consultation, it was decided that the patient should be kept under medical management for six to eight weeks and then be evaluated as a possible candidate for portacaval shunt.

Final Admission

In the interim of two months, the patient continued to have easy fatigability and anorexia. No further episodes of melena or hematemesis occurred. He gained 12 to 15 lbs. and had abdominal swelling and pedal edema in spite of frequent injections of mercurial diuretics. He also experienced frequent episodes of sharp right upper quadrant and right flank pain.

Physical examination on admission revealed a pale, wasted white man with no obvious icterus. The subcutaneous nodules were again noted. There was no lymphadenopathy. Dullness to percussion, decreased breath sounds, and tactile fremitus were noted at the base of the right lung posteriorly. No rales or rhonchi were heard. There was no change on examination of the heart. The abdomen was distended with obvious ascites. The liver was palpable 6 cm. below the right costal margin and was moderately tender. A suggestion of fullness and a possible indiscrete mass were palpable in the left upper quadrant and the left flank. There was 3 plus pitting pretibial and pedal edema. The patient was alert and no asterixsis was demonstrated.

Laboratory data showed a hematocrit of 40 per cent, hemoglobin 12.7 Gm., and a white blood cell count of 6,000 with a normal differential count. The urinalysis was not remarkable. The serum sodium was 132, potassium 4.0, chloride 102, and the CO_2 combining power 28 mEq.; bilirubin 2.2 mg. with 1.2 mg. direct; SGOT 104, LDH 520 units. The BUN was 16 mg., cholesterol 193 mg. with 63 per cent esterification; prothrombin time 60 per cent; alkaline phosphatase 24 units; total protein 7.8 Gm. (3.3 albumin, 4.8 globulin). Serum protein electrophoresis on 7.7 Gm./100 ml. protein showed albumin 38.6 per cent, $alpha_1$ 8 per cent, $alpha_2$ 11.4 per cent, beta 16.6 per cent, gamma globulin 25.4 per cent.

X-ray film of the chest revealed evidence of minimal pleural fluid bilaterally. An esophogram confirmed the presence of very large varices. The electrocardiogram was within normal limits.

During his hospital stay of 25 days the patient remained afebrile. Attempts at diuresis resulted in a 20 lb. weight loss. He complained frequently of moderately severe back, and generalized abdominal, pain. A diagnostic paracentesis yielded a clear yellow fluid containing 200 erythrocytes, 100 leukocytes (88 per cent lymphocytes), 400 mg. of protein, and was Papanicolaou class I. An inferior venacavagram was interpreted as normal. Carbon dioxide study of the hepatic veins was attempted but was unsuccessful. Liver scan with both radioactive gold and rose bengal was consistent with a small liver and an enlarged spleen.

On the 18th hospital day he was given Thorazine® because of nausea and vomiting. Following this he became extremely drowsy and difficult to arouse. On the 22nd hospital day he had an episode of hematemesis followed by melena. During the next few days the patient deteriorated rapidly and he died on the 25th hospital day.

CLINICAL DISCUSSION

DR. GREENBERGER: This case concerns a 65 year old white man who eight years prior to his final illness had a resection of a transitional-cell carcinoma of the bladder. He then did well until his final illness, which spanned seven months and was characterized by weakness, easy fatigability, anorexia, a weight loss of at least 15 lbs., wasting, right upper quadrant and flank pain, at least two distinct episodes of upper gastrointestinal bleeding with hematemesis, an adverse reaction to Thorazine characterized by drowsiness and obtundation, and terminal coma which was most likely hepatic in origin. He had subcutaneous nodules; he had mild but persistent jaundice; he had recurrent ascites and edema; he had hepatomegaly with a tender liver; a heart murmur. We are told that he also had a pleural effusion although we may not be able to see these on the x-rays, a questionable left upper quadrant mass, anemia due to blood loss, and clear-cut portal hypertension as reflected by the fact that he had esophageal varices, a very high intrasplenic pressure, ascites, and splenomegaly. Any diagnosis or diagnoses that are going to be invoked must account for all of these.

On the second admission he had significant hyperbilirubinemia, a slightly increased SGOT, and depressed prothrombin time which improved to near normal after vitamin K, an abnormal cephalin flocculation and thymol, a depressed albumin, normal globulin, a long BSP retention, and a slightly elevated alkaline phosphatase. I would interpret this set of chemistries as being most consistent with hepatocellular rather than obstructive disease. At his third admission his bilirubin was still elevated and his transaminase was now 104 units, his globulins 4.7 Gm. His alkaline phosphatase had increased to 24 units, which is a very strong straw in the wind that this man had either infiltrative or neoplastic liver disease because the alkaline phosphatase is disproportionately elevated as compared to his serum bilirubin levels.

In the interval between his second and third ad-

missions this patient developed refractory ascites despite diuretic therapy. This is a fairly common occurrence in cirrhotics in our clinic population because they are unable to stay on a diet that is rigidly restricted in sodium. Alternatively, the refractory ascites might be due to progressive liver disease.

After he received Thorazine he became drowsy and then had another episode of gastrointestinal bleeding with hematemesis, which was probably due to esophageal varices. We know that significant gastrointestinal hemorrhage is a common precipitating cause of hepatic encephalopathy and it is not surprising then that he deteriorated and died in coma, very likely hepatic coma.

His x-rays showed that this man had unequivocal portal hypertension with esophageal varices and a patent extrahepatic portal system. I think the venacavagrams may offer us a clue; we can't be dogmatic about it but I think that they are abnormal. The failure of the CO_2 study again is a straw in the wind that there may be something wrong with his hepatic veins. I think that the crux of this case is then an interpretation of the portal hypertension, splenomegaly, jaundice, and ascites.

Pathophysiology of Portal Hypertension

I thought it would be worth while to review very briefly some of the pathophysiology of portal hypertension as it relates to differential diagnosis. Portal hypertension is usually classified into presinusoidal and postsinusoidal causes. Presinusoidal causes are extrahepatic and intrahepatic. Common extrahepatic presinusoidal causes include portal vein thrombosis, splenic vein thrombosis, or pancreatic lesions. In these disorders the intrasplenic pressure is high because the lower circuit is blocked. The wedge pressure is normal. The patients usually have splenomegaly, and jaundice and ascites are rare. In intrahepatic presinusoidal portal hypertension, which might be exemplified by schistosomiasis, congenital hepatic fibrosis, portal zone infiltration such as Hodgkin's, leukemia, sarcoid, etc., again the intrasplenic pressure is high, the wedge pressure is normal, splenomegaly is frequent, but jaundice and ascites are infrequent.

In postsinusoidal extrahepatic portal hypertension, the entity that we can be very concerned about today is hepatic vein thrombosis, or Budd-Chiari syndrome. Where there is thrombosis of just the hepatic veins, the wedge pressure may be high but the splenic pressure may be normal or slightly increased. Patients who have hepatic vein thrombosis and also have a high intrasplenic pressure, usually have thrombosis of their portal system as well, and at least at the time of this examination our patient did not have this. Splenomegaly accordingly is less frequent, jaundice is infrequent; ascites is usually present and is often refractive. The commonest cause of intrahepatic postsinusoidal portal hypertension is cirrhosis, where both the intrasplenic and the wedge pressure are elevated; splenomegaly, jaundice, and ascites are all common.

With this as a background then, I think we should proceed to the differential diagnosis. First of all, what about tuberculous peritonitis? Tuberculous peritonitis has to be considered in any patient who has persistent ascites and chronic liver disease. The absence of fever and a positive skin test does not rule out the diagnosis. But actually there is very little else to suggest this diagnosis and I think that tuberculous peritonitis is unlikely in this individual.

Hepatitis?

Could he have had viral hepatitis with submassive necrosis? If this man had had antecedent viral hepatitis, I think after six to seven months he would have had cirrhosis. I think the difficulty in making this diagnosis is that there is no clear-cut antecedent etiologic insult. There was no contact with jaundiced persons and, more importantly, he had had no blood or blood products, and hepatitis in persons over 40 is almost always associated with serum hepatitis.

We are told that this man had had a carcinoma of the bladder resected eight years previously. Could he have had recurrent carcinoma of the bladder with metastases to his liver? I think that this is unlikely for three reasons: First of all, the incidence of liver metastases in bladder carcinoma is reasonably low. Second, most patients who have bladder carcinoma and die, die either a renal or a septic death. And third, there was no clue during his final admission that he had recurrent carcinomatous disease in his bladder.

Hypernephroma and Budd-Chiari Syndrome

We are told that this man had a questionable left upper quadrant mass and we have to seriously consider hypernephroma because these tumors are prone to involve the hepatic veins and give a Budd-Chiari syndrome. The usual clinical presentations of hypernephroma are pain, a palpable mass, and hematuria in about 50 per cent of the patients. The most significant finding is a positive IVP. I think the fact that the IVP was negative in this case is strongly but not conclusively against the diagnosis of a hypernephroma.

One of the entities that we very seriously have to consider is a carcinoma of the pancreas, and you are all familiar with the symptoms and the physical findings of patients with carcinoma of the pancreas. I think that this man's story is certainly consistent with a neoplastic process and certainly consistent with a carcinoma of the pancreas. The things that bother me are that in patients with carcinoma of the pancreas who have ascites I would like to see portal vein invasion, or I would like to have evidence of peritoneal implants, and an analysis of his peritoneal

fluid gave no such evidence. So I think that this diagnosis is going to be a little less likely than some of the others that we are going to come to.

Could this patient have a stone in his common duct that was leading to incomplete obstruction, which was of long standing and which led to secondary biliary cirrhosis? I don't think this man had secondary biliary cirrhosis for a number of reasons. First of all, it usually takes at least 9 to 12 months of high-grade obstruction or incomplete obstruction to get this picture. Second, almost all patients who have biliary cirrhosis of the secondary variety have a triad of findings: They have elevated blood lipids, they have xanthomatous skin lesions, and they have pruritus. Our patient had none of these. And lastly, portal hypertension, varices, ascites, and liver cell failure are late complications and take as long as five years to develop. For these reasons I do not think that this diagnosis applies in this case.

Now we come to one of the two major possibilities and that is an occlusion of the hepatic veins — the so-called Budd-Chiari syndrome. The commonest known causes of hepatic venous thrombosis are polycythemia vera and hypernephroma. The cardinal sign of this condition is recurrent and significant ascites. Hepatomegaly, abdominal pain, and edema occur frequently; splenomegaly is less frequent, and jaundice is infrequent and usually of mild degree. The points to be emphasized here are that splenomegaly, jaundice, ascites, esophageal varices, and hydrothorax are distinctly uncommon in patients who have the idiopathic variety. However, in patients who have the neoplastic variety these findings are perhaps more frequent. We will come back to a consideration of this entity later.

Hepatoma?

The last entity that has to be seriously considered is that this man had a hepatoma. Three-quarters of the patients with a hepatoma have underlying cirrhosis, more commonly the postnecrotic and infrequently the nutritional type. The symptoms of hepatoma are those you would expect in a patient with neoplastic disease. Hepatomegaly is almost a uniform finding; ascites and jaundice are less frequent; edema, tender liver, and splenomegaly a little infrequent; terminal coma occurs in about one fifth of the patients. The most common presentation of patients with a hepatoma is that they look like a cirrhotic and they may have known cirrhosis, and they start to go downhill and deteriorate without apparent reason. This is when you should be seriously thinking about hepatoma.

The important point here is that these patients can also present with a Budd-Chiari syndrome due to hepatic venous occlusion. When should this diagnosis be thought of? In a cirrhotic who starts to deteriorate, in a patient who has hepatomegaly and a disproportionately elevated alkaline phosphatase versus his bilirubin level, in a patient who has hemorrhagic ascites although malignant cells are not found very commonly. Conversely, if a patient has a normal alkaline phosphatase and no increase in his liver size, it's very hard to make a diagnosis of a hepatoma.

I think, as I indicated previously, that the diagnoses in this case certainly have to account for several observations. First, the patient had portal hypertension. This was probably intrahepatic and postsinusoidal because he had a patent extrahepatic portal system, and it was probably of long duration because of the marked esophageal varices. He had mild but persistent jaundice, he had refractory ascites, and terminally he had coma which might well have been the hepatic type. I think that he did have hepatic venous occlusive disease, and I think that his progressive deterioration over a seven month period smacks of neoplastic disease.

So how do you tie all this together? I think the one diagnosis that would most satisfactorily account for all of his symptoms is cirrhosis with the development of a hepatoma, and associated with the hepatoma he had hepatic venous occlusion with thrombosis of his hepatic veins, or occlusion of the veins by tumor thrombi. The alternative diagnosis that I cannot exclude is that he had a Budd-Chiari syndrome, that is, thrombosis of his hepatic veins associated with underlying tumor. There are four tumors that are likely to give rise to a Budd-Chiari syndrome: carcinoma of the kidney, which we can't diagnose with a normal IVP; carcinoma of the lung, for which there is really no clinical evidence; carcinoma of the liver, which I think is the most likely carcinoma that he could have had, or carcinoma of the pancreas, which is known to be associated with a high incidence of venous thrombosis. I think that our patient had venous occlusive disease and a malignant neoplasm. I think the tumor was most likely a hepatoma but I wouldn't be surprised if it was found in the pancreas.

General Clinical Discussion

DR. WALL: We have had a very comprehensive review of hepatic disease and I think the only things we haven't mentioned are *Clonorchis sinensis* and *Fasciola hepatica.* One thing I would like to ask our discussant is: What about these subcutaneous bumps he had had all this time?

DR. GREENBERGER: When somebody has painless subcutaneous nodules of long standing, the differential diagnosis would be von Recklinghausen's disease or lipomatosis. I am really unable to link the subcutaneous nodules with his liver disease and his portal hypertension.

QUESTION: As long as you have been entertaining a diagnosis of possible pancreatic carcinoma, why not do a secretin stimulation test and look for malignant cells in the duodenal juice?

DR. GREENBERGER: I have had some experience with the secretin-pancreozymin test. This is a tedious procedure and if it is not done properly the results are very hard to interpret.

QUESTION: I wondered whether there is any possibility that the Thorazine he was given on his last day may have been a precipitating factor in his death?

DR. GREENBERGER: Post-Thorazine-induced hepatitis is a hepatitis either with or without cholestasis. It very rarely, if ever, produces massive liver cell necrosis. I think that the problem here is that these people don't handle any type of sedative very well. You have seen hepatic coma induced by Librium®, Thorazine, what have you, even in modest doses.

QUESTION: Dr. Greenberger, would you like to comment about the association of hepatomas and cirrhosis?

DR. GREENBERGER: This is a knotty question in a way. I think most people agree that about three quarters of all hepatomas are associated with underlying cirrhosis, and since I think this man had a hepatoma I am almost obligated on the basis of this statistical probability to say that he had cirrhosis. But I also felt that the cirrhosis would best account for the severe long-standing portal hypertension that he had.

CLINICAL DIAGNOSIS

1. Budd-Chiari syndrome due to hepatic vein obstruction by:
   (a) Hepatoma
   (b) Carcinoma of the pancreas.
2. Hepatic cirrhosis, postnecrotic type.

PATHOLOGIC DIAGNOSIS

1. Infectious hepatitis with postnecrotic cirrhosis.
2. Mixed type of cholangiohepatoma with invasion of the hepatic veins and the inferior vena cava and widespread metastasis.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The body was that of a slightly jaundiced, moderately cachectic individual with severe pedal edema. There were only a small amount of ascites in his abdominal cavity and a moderate bilateral hydrothorax. The heart was small. The right atrium contained a large tumor thrombus which obviously represented a continuation from a similar thrombus in his inferior vena cava. The latter did not completely obstruct the lumen of the vessel. Both lungs were studded with numerous tumor nodules which showed a yellowish-green discoloration and central necrosis. The spleen was markedly enlarged and firm. The portal vein was completely free of thrombosis, and there was marked dilatation of the branches leading towards the stomach and esophagus.

The liver was of normal size and showed a marked nodularity, the nodules measuring 1 to 6 mm. in diameter. In addition numerous tumor nodules could be distinguished separated by areas of fibrosis. All hepatic veins were completely occluded by soft, necrotic tumor tissue which extended into the vena cava. The esophagus showed partially eroded varices. The stomach showed numerous recent erosions. Only a moderate amount of brownish-black material was present in the small intestine. The right adrenal was completely replaced by a large tumor mass which seemed to be continuous with the tumor in the right lobe of the liver. Examination of the genitourinary system showed no remarkable changes. The bladder showed no evidence of tumor recurrence. The retroperitoneal lymph nodes and the lymph nodes at the liver hilus were enlarged and replaced by tumor.

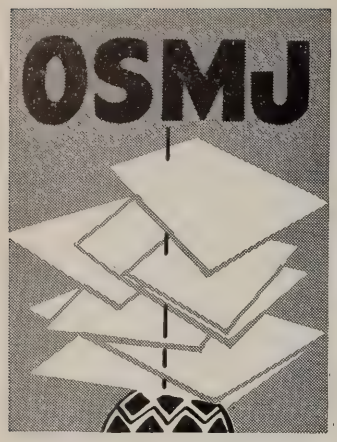
Microscopic sections showed mural thrombi composed of tumor cells in the right atrium and ventricle. The myocardium showed the nonspecific myocarditis often seen in viral infections. The metastatic nodules in the lung showed a well differentiated liver-cell hepatoma with formation of trabeculae and evidence of bile production. Sections through the spleen showed congestive splenomegaly with marked myeloid metaplasia. The pancreas was not remarkable.

Sections through the liver showed a rather extensive postnecrotic cirrhosis with many foci of active viral hepatitis. There was typical ballooning degeneration of the liver cells with massive cytoplasmic inclusion bodies. The tumor itself showed varying pictures of liver cell hepatoma of the mature and embryonal types with adenocarcinoma of the cholangiocarcinoma type. Bile could be demonstrated in some of the glands by special stains. In many respects the tumor resembled histologically the hepatoma found in trout. Most of the hepatic veins were filled with tumor emboli. Sections through the bone marrow showed extensive replacement of the bone marrow by tumor metastases of the well differentiated hepatoma type. We believe this fact accounts for the compensatory myeloid metaplasia in the spleen.

The histological picture of his subcutaneous nodules was that of benign fibrolipoma.

In conclusion then, we feel that the patient suffered from a slowly progressive infectious hepatitis which was still active at the time of his death but had already caused considerable scarring leading to postnecrotic cirrhosis. He subsequently developed a hepatoma of the mixed-cell type which occluded the hepatic veins and produced tumor thrombi in the vena cava and the right atrium with extensive metastases to the lungs, adrenals, and lymph nodes. That postnecrotic cirrhosis and hepatoma have some etiologic relationship has been postulated many times but never proved. We know that most, but not all, hepatomas develop in a cirrhotic liver particularly of the postnecrotic type.

I would like to commend the clinical discussant, who recognized the Budd-Chiari syndrome as the basic factor in the patient's symptoms.



NEWS AND Organization Section

Proceedings of The Council...

A Report of Matters Discussed and Actions Taken At Regular Meeting in Columbus, September 9-11

A REGULAR MEETING of The Council of the Ohio State Medical Association was held September 9-11, 1966, at Stouffer's University Inn, Columbus. All members of The Council were present except Dr. Theodore L. Light, Dayton, Councilor of the Second District; Dr. Robert N. Smith, Toledo, Councilor of the Fourth District; and Dr. George Newton Spears, Ironton, Councilor of the Ninth District. Others attending the meeting were: Drs. Edwin H. Artman, Chillicothe, John H. Budd, Cleveland, Richard L. Meiling, Columbus, Frederick P. Osgood, Toledo, Charles A. Sebastian, Cincinnati, George W. Petznick, Cleveland, Carl A. Lincke, Carrollton, Edmond K. Yantes, Wilmington, Robert E. Tschantz, Canton, AMA delegates; Drs. J. Robert Hudson, Cincinnati, H. T. Pease, Wadsworth, Kenneth D. Arn, Dayton, Harry K. Hines, Cincinnati, AMA alternate delegates; Dr. Perry R. Ayres, Columbus, Editor, *The Ohio State Medical Journal;*

Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA field representative; Dr. Wendell A. Butcher, Columbus, chairman of the OSMA Committee on Mental Health; Dr. Emmett W. Arnold, Columbus, Ohio director of health; Dr. Oscar W. Clarke, Gallipolis; Dr. Neil C. Andrews, Columbus, coordinator of research for Public Law 89-239; Messrs. Mike Asher, president, Richard McDermott, vice-president, and Joel Ginsberg, representing the Student AMA Chapter, Ohio State University College of Medicine; and Messrs. Page, Edgar, Gillen, Traphagan, Campbell, and Moore of the OSMA staff.

Minutes Approved

Minutes of the meeting of The Council held July 23-24 were approved by official action.

Ninth District Councilor

The resignation of Dr. George Newton Spears, Ironton, Councilor of the Ninth District, was accepted with regret.

Dr. Oscar W. Clarke, Gallipolis, was selected by The Council to serve as Ninth District Councilor until the next Annual Meeting of the House of Delegates, at which time the office will be filled as provided for in the Constitution and Bylaws.

Auditing and Appropriations Committee Appointment

Dr. Richard L. Fulton, Columbus, was appointed to serve on the OSMA Auditing and Appropriations Committee to succeed Dr. Spears.

Civil Rights Pledges

The Council approved a letter dated September 12 from Dr. Meredith to the Honorable Denver L. White, director of the Ohio Department of Public Welfare, seeking the elimination of the civil rights pledges and agreements.

Membership Statistics

The following membership statistics were announced by Mr. Page: OSMA membership as of September 7, 1966, was 9,997, compared to a total membership of 9,905 on September 7, 1965, and 10,042 on December 31, 1965. He reported that of the 9,997 members, 8,941 were affiliated with the AMA.

Policy on Waiver of Dues for 1967

By official action, The Council adopted the following policy with regard to waiver of annual dues for the calendar year 1967:

A. That dues for new members in practice, affiliating with the OSMA during the last six months

of the calendar year 1967, namely, July 1 to December 31, inclusive, shall be $25.00, one-half the regular per capita dues of $50.00. The prorating of dues shall not apply to former members reaffiliating.

B. That the following procedures shall apply during 1967 with respect to OSMA annual dues of members on temporary military service and not making military medicine a career.

1. State Association dues for 1967 shall be waived for members on temporary military service and not making military medicine a career.

2. State Association dues for 1967 shall be waived for physicians who were members of the Association in 1966 and who enter such services during the calendar year 1967 before the payment of 1967 dues.

3. A refund of membership dues will not be made if a member enters such services in 1967 after his 1967 dues are received at the Columbus office of the Association.

4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

C. Annual Ohio State Medical Association dues for 1967 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be $7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges.

Dues Exemption for Financial Emergencies

It was the interpretation of The Council that Resolution No. 2, adopted by the 1966 House of Delegates regarding waiver of dues for hardship cases, is to be effective January 1, 1967.

Report of Ohio Director of Health

Dr. Emmett W. Arnold, Ohio director of health, addressed The Council on current and future developments concerning public health in Ohio. Dr. Arnold announced that his department is developing regulations for submission to the Ohio Public Health Council which will permit the integration of clean gynecological patients on obstetric floors of general hospitals.

Discussing the PKU (phenylketonuria) program, Dr. Arnold said that he would designate as regional laboratories certain ones which may be approved for conducting PKU tests. Approval will be restricted to those laboratories doing a large number of such tests.

Dr. Arnold then discussed the possibility of legislation being introduced in the next Ohio General Assembly for the establishment of a hospital licensure program.

The Council directed the OSMA Committee on Hospital Relations to give attention to this matter.

With regard to nursing homes, Dr. Arnold announced that the regulations governing the homes have been implemented and revised and that 1,087 homes are under "permanent licensure."

Turning to Federal legislation, Dr. Arnold discussed Senate Bill 3008, the public health bill developed by the state and territorial health officers to stabilize grant programs to public health departments. He told The Council that two billion dollars a year in grants are predicted if this legislation passes and that they will be administered by the State Health Departments. He said the bill would permit a certain flexibility in the way the money is spent and would do away with categories.

Meeting of AMA Delegates and Alternates

Dr. Budd reported on the meeting of the AMA delegates and alternates held September 9. The report as a whole **was approved.** It included a request that a letter be sent from the OSMA president and chairman of the Ohio delegation to the chairman of the Board of Trustees of the AMA inquiring as to how and when the AMA councils and committees are carrying out AMA policy concerning qualifications for staff membership and maintenance of the "open staff" concept as set forth in the reference committee action on Resolution No. 58, as approved by the House of Delegates.

Also included in the report was the approval of two resolutions. One resolution would require that published reports of the reference committees be available to members of the AMA House of Delegates at least 24 hours prior to the call to order of the session of the House at which they are to be considered. The other resolution would require that resolutions and reports of the Board of Trustees and Councils of the AMA be at the AMA headquarters at least 30 days prior to the opening session of the House of Delegates at annual and clinical conventions, except resolutions of an emergency nature which could be introduced at the opening session of the House if accepted by two-thirds of those present and voting.

Dr. Budd was re-elected chairman and Dr. Petznick was re-elected vice-chairman of the Ohio delegation.

Hospital-Based Physicians

Dr. Meredith appointed the following committee to draft a resolution on hospital-based physicians for presentation at the regular session of the AMA: Dr. Robechek, chairman, Drs. Tschantz, Budd and Schultz. Dr. Meredith requested the OSMA legal counsel to assist the committee.

Quarterly AMA Sessions

The Council directed the Executive Secretary to send a communication to the American Medical Association requesting that representatives from Ohio be heard on AMA Resolution No. 2 (1966 Annual Convention), proposing quarterly sessions of the AMA House of Delegates. This matter is being studied by the AMA Board of Trustees and a report is expected at the Clinical Convention in November at Las Vegas.

Definition of "Usual and Customary"

The Council authorized Dr. Budd and members of the staff to appear before the AMA Committee on Insurance and Prepayment Plans, September 25, with regard to presenting testimony on the definition of the term "usual and customary fee." The Council approved a discussion of the problem with other interested state medical associations in connection with preparing testimony for the meeting.

Asks Education on "Direct Billing"

The Council instructed President Meredith to write a letter to the American Medical Association, advising that many physicians do not understand "direct billing" and asking for the implementation of the substitute resolution (Res. 73 and Res. 105) which asks that the membership be informed that Medicare Regulation No. 5 will not apply to physicians who have no financial relationship with a hospital covering medical services to patients and who do not accept assignments but bill directly.

Supports New Jersey Letter

A copy of a letter from the Medical Society of New Jersey to the AMA Board of Trustees, protesting sections of an article written by Russell B. Roth, M. D. in the August 1, 1966, Volume 197, No. 5 of the *JAMA* under the title "Medicare: Its Problems for Practicing Physicians," was considered by The Council. The protest involves the author's suggestion that Part B Medicare funds might be adapted to pay residents if residents were given a different title. The New Jersey letter also pointed out that the author suggested that it might be necessary to change the Medicare law so that residents could be paid from Part B funds.

As the communication from the Medical Society of New Jersey pointed out, the AMA House of Delegates in June, 1963, adopted a policy ". . . opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage."

The Council voted to support the protest of the Medical Society of New Jersey and requested the Executive Secretary to send a letter advising of this action.

Presidential Communication

A communication from Dr. Charles L. Hudson, Cleveland, President of the American Medical Association, was accepted for information.

Executives' Conferences

Dr. Crawford and Dr. Howard reported on the Ohio Medical Society Executives Conference held in connection with the AMA Public Relations Institute and the Association of American Medical Executives in Chicago, August 23.

Mr. Weihaupt discussed a proposed AMA seminar for new medical society executives.

1967 County Society Officers' Conference

Plans for the 1967 County Society Officers' Conference to be held late in February at the Fort Hayes Hotel, Columbus, **were approved** by The Council.

Military Advisory Committee

In connection with the activities of the Ohio Military Advisory Committee, a request by Dr. Drew L. Davies, chairman, dated August 16, 1966, to the National Selective Service System for funds to be applied to the committee's expenses of operation, **was approved.**

Committee Reports

Scientific Work — The minutes of the meeting of the Committee on Scientific Work held July 30-31 were presented by Mr. Traphagan. The report **was approved** with the following exceptions:

1. The meeting of the House of Delegates was shifted from 2 P.M., Tuesday, May 16, to 8 P.M., Monday, May 15.
2. All Tuesday sessions were shifted to the Sheraton Columbus Motor Hotel.
3. The meetings of the House of Delegates Reference Committees were scheduled for Tuesday morning.
4. The Montgomery County Medical Society Glee Club to be invited in lieu of "Sing Out '67."

Insurance Committee — Mr. Campbell presented the report of the OSMA Committee on Insurance, which held a meeting on August 14. He advised The Council that investigation continues with regard to travel accident insurance proposals covering committeemen, officers and staff of the OSMA.

The Council **approved** a long term disability plan covering employees of the Ohio State Medical Association and stipulated that a 90-day waiting period be incorporated in lieu of the 180-day waiting period.

The Council re-referred to the Insurance Committee the implementation of Amended Resolution No. 24 (OSMA 1966) with regard to the development of a suggested billing form for Ohio physicians. Additional information obtained by the staff in conference with the author of the resolution indicated that the

intent of the resolution was the development of a billing form rather than a claims form as assumed by the committee. The Council also asked that the availability of the previously developed OSMA standard claims form be publicized to the membership.

The Council **approved** the stepping up of the Ohio State Medical Association Blue Cross coverage for employees from 70 to 120 days and stipulated that diagnostic x-ray be excluded since this is a coverage provided by Blue Shield.

A statement on coordination of benefits in health insurance coverages was re-referred to the committee for additional study.

The goals of Amended Resolution No. 32 (OSMA 1966), asking the voluntary health insurance industry not to cancel contracts but to continue to offer contracts for persons 65 and older, **were approved,** as well as the committee's suggestion for implementation.

The action of the committee tabling further implementation of Amended Resolution No. 37 regarding health insurance for migrant workers **was approved.**

The report as a whole **was approved** as amended.

Mental Health — Dr. Butcher reported for the OSMA Committee on Mental Health. The Council **approved** a proposal of the committee to sponsor and support in the 107th Ohio General Assembly legislation to provide statutory autonomy for mental retardation within the Division of Mental Health of the Department of Mental Hygiene and Correction and to provide for leadership by the medical profession in the mental retardation field.

Also **approved** by The Council was the committee's proposal that the OSMA sponsor and support legislation in the 107th Ohio General Assembly to create a regulatory Board of Mental Health.

A proposal to require a separation of the Department of Mental Hygiene and Correction into two departments, one of mental hygiene and one of correction, was tabled indefinitely.

The Council authorized Dr. Butcher to work with the director of the Department of Mental Hygiene and Correction in developing the best legislation possible and stipulated that the draft be brought to The Council for consideration before introduction.

The Council recommended Dr. Butcher for appointment to the Ohio Citizen's Committee on Comprehensive Mental Health Planning.

Amendments to Constitution and Bylaws

The Council voted final approval to the amendments to the Constitution and Bylaws of the Cleveland Academy of Medicine. It was suggested that the Academy be notified that no provision is included in the current bylaws for giving notice of special membership meetings. The Council expressed the opinion that a provision for a minimum number of days notice should be established.

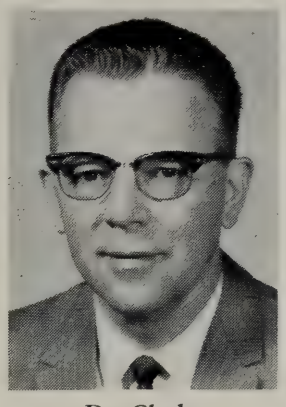
Ohio Medical Indemnity, Inc.

A proposal for the development of a "deferred income" plan in connection with Ohio Medical In-

Dr. Clarke Named by The Council As Ninth District Councilor

The Council at its meeting on September 10-11 appointed Dr. Oscar W. Clarke, of Gallipolis, to serve as Councilor of the Ninth Councilor District until the 1967 OSMA Annual Meeting.

The vacancy in the District was occasioned by the resignation of Dr. George N. Spears, of Ironton, who was first elected to The Council in 1964 and re-elected at the last annual meeting of the House of Delegates. His resignation was for personal reasons, and The Council accepted his request with regrets.



Dr. Clarke

Dr. Clarke is a practicing physician in the Gallipolis area, specializing in internal medicine, and is chief of the Department of Internal Medicine at the Gallipolis Clinic and the Medical Center Hospital.

He is a graduate of the Medical College of Virginia, a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and a charter member and former trustee of the Ohio Society of Internal Medicine.

Dr. Clarke is a past president of the Gallia County Medical Society. On the state level he has served on the OSMA Committee on Hospital Relations and the Committee on Workmen's Compensation.

In Heart Association activities he is a member of the council of the Gallia County Heart Association, a trustee of the Central Ohio Heart Association, and a member of the Education Committee of the Ohio Heart Association.

He is president of the Gallipolis City Board of Health, a past president of the Gallipolis Rotary Club, past president of the Tri-County Community Concert Association, member of the executive committee of the Gallia County Community Industrial Council, and a trustee of the Medical Memorial Foundation.

Mrs. Clarke, the former Susan Frances King of Kalispell, Montana, is a member-at-large of the Woman's Auxiliary to the OSMA. The Clarkes have three daughters, Susan, Elisabeth, and Jennifer. Family affiliation is with the First United Presbyterian Church of Gallipolis.

demnity was submitted in writing by Mr. Joseph V. Lane, Jr. The Council expressed the opinion that such a plan was not feasible and the executive secretary was instructed to so notify Mr. Lane.

Billing Procedures for Specialists

Considerable correspondence concerning the activities of radiologists, pathologists and other specialists in establishing their own billing procedures for professional services was reviewed by The Council and progress reports were discussed.

A letter from Dr. Oscar M. Weaver, Kenton, Ohio was presented to The Council. The Executive Secretary was instructed to communicate with Dr. Weaver and thank him for his interest.

Hospital Prepayment Plans

The Council discussed the implementation of Substitute Resolution No. 16 (1966 OSMA) to petition the Ohio director of insurance to require removal of medical service benefits from hospital prepayment plans. It was The Council's opinion that the time has not yet arrived to implement this resolution and it was decided to defer action on this petition until the appropriate time, as determined by The Council.

Public Law 89-239

Dr. Meiling presented for the information of The Council developments in the regional medical programs to combat heart disease, cancer, stroke, and related diseases. Such information was supplemented by a report from Dr. Neil C. Andrews, coordinator of research for planning the project under P.L.89-239 in this area. An article covering the reports of Drs. Meiling and Andrews is presented on page 1191 in *The Ohio State Medical Journal.*

Miscellaneous Correspondence

A communication from Dr. Arthur Collins, chairman of the OSMA Committee on Eye Care, was received for information.

A communication from the Cosmetic Therapy Association of Ohio was received for information.

To Study "Pima County Plan"

A file on proposals, such as the Pima County Plan and the New Jersey Plan, to deal with malpractice suits was referred to the Judicial and Professional Relations Committee for study.

Report of Auditing and Appropriations Committee

The Council **approved** the report of the Auditing and Appropriations Committee which met on September 9. Such report included the authorization for the purchase of a graphotype machine so that addressograph plates may be prepared in the State Association office.

The purchase of a new file cabinet for the membership department was also **approved.**

The bill submitted by the OSMA general counsel for services from December 1, 1965 to July 31, 1966 **was approved** as a part of the report.

Renewal of subscriptions to *Today's Health* for 37 Ohio colleges **was authorized** by The Council.

OSU Student AMA Chapter

Messrs. Asher, Ginsberg and McDermott, OSU medical students, discussed with The Council the proposal from the executive committee of the OSU Student AMA Chapter. Such proposal involved the development of a constitution and bylaws by the chapter modeled after that of the Ohio State Medical Association. In addition, the chapter asked the OSMA to share the expense of distributing the quarterly chapter newsletter, *SAMAntics,* to every OSMA member and to every medical student in Ohio, the OSMA part of the expense to be $350 per issue. The Council **approved** the proposals with the stipulation that the publication and distribution of the newsletter *SAMAntics* be on an experimental or trial basis for the remainder of the year.

Journal Editorial Committee

By a vote of The Council there was established an editorial committee for *The Ohio State Medical Journal* to be composed of the following: President, President-Elect, Past President, Executive Secretary, Director of the Department of Public Relations of the Ohio State Medical Association and the Executive Editor of *The Journal.* The Executive Editor was authorized to act with regard to a proposed contractural change with the State Medical Journal Advertising Bureau.

Cancer Tests

A communication proposing routine Pap smears on all women admitted to hospitals was referred to the Cancer Committee of the Ohio State Medical Association for study.

AMA-ERF Campaign

It was decided by The Council that solicitation of funds for the AMA-ERF should take place in the Fall as previously.

Travel Committee

With regard to a proposal for a travel committee under the auspices of the Ohio State Medical Association, The Council voted not to establish such a committee.

There being no further business, The Council adjourned.

Attest: HART F. PAGE,
Executive Secretary

Heart-Cancer-Stroke Plan in Ohio...

Ohio State University Applies for Planning Grant To Organize Regional Program in 61 Ohio Counties

OHIO STATE University College of Medicine has applied for a planning grant to organize, implement and prepare a regional medical program in accordance with the intent of Public Law 88-239, or the Heart Disease, Cancer and Stroke Amendments of 1965. The proposed regional medical program concerning heart disease, cancer, stroke and related diseases would encompass 61 counties occupying the southern two-thirds of the State of Ohio, with the exception of the Cincinnati area excluding Hamilton, Butler, Warren, and Clermont Counties.

Dr. Richard L. Meiling, dean of the OSU College of Medicine, and Dr. Neil C. Andrews, member of the OSU faculty and coordinator in behalf of the university of research for the heart, cancer, and stroke program, presented a summary of the proposed plan at the September meeting of The Council of the Ohio State Medical Association.

Both Dr. Meiling and Dr. Andrews emphasized that the plan would encourage the care of the patient in his own community, the regional center providing pertinent knowledge of research and instrumentation as provided by law to physicians on the local scene.

Following is a summary of the proposed plan:

Ohio State University with its past experience of patient care, research programs, undergraduate, graduate and postgraduate training, programs of continuing education and its Ohio Medical Education Network for physicians and nurses, proposes to:

A. Establish a Regional Advisory Committee in accordance with the suggestions and regulations of Public Law 88-239. This Committee will meet regularly and provide advice, review and evaluation to the program.

B. Organize a Medical Program Planning Committee which will prepare the regional medical program. Initially this Committee will be composed of members of the medical school faculty, **but will be enlarged as the need becomes apparent to include those individuals from the communities of action** within the regional program.

C. Survey individuals and representatives of organized professional groups, hospitals and volunteer health organizations in the 61 counties included in the regional program to assess their needs, so that better care can be provided to their patients affected by heart disease, cancer, stroke and related diseases in their communities.

D. Plan and develop a Demonstration Unit for the diagnosis, instrumentation, and treatment of patients with **cardiovascular disease which will be used for the education of physicians, nurses, physiotherapists, occupational therapists, and other related personnel. This unit will serve as an exemplary prototype for additional units to be established throughout the region.**

E. Plan and develop a Demonstration Unit for the diagnosis, instrumentation, and treatment of patients with **stroke** which will be used for education of physicians, nurses, physiotherapists, occupational therapists and other related personnel. This unit will be as an exemplary prototype for additional units to be established throughout the region.

F. Evaluate the feasibility of a **central cancer registry** for the region and investigate the feasibility of establishing **coronary artery disease, heart disease, and stroke and other related disease registries.**

G. Plan and aid in developing an **informational retrieval system** concerning the literature of coronary artery disease through the Heart Hot Line of the Cox Coronary Heart Institute and Data Corporation of Dayton. The potential value of this system which will provide abstracts, as well as bibliography, will supplement the objectives of the MEDLAR System of the National Library of Medicine which **will become functional at the Ohio State University College of Medicine during the present year.**

H. Plan and develop a feasibility study for television for consultation and education in the areas of heart disease, cancer, stroke, and related diseases by a two-way audio-video communication system between a relatively remote area in southeastern Ohio and the Ohio State University College of Medicine.

I. Establish a program of education throughout the region to assure physicians, medical organizations, hospitals, and other interested institutions that **the purpose of The Ohio State University College of Medicine in the areas of heart disease, cancer, stroke,** and related diseases **is to encourage the care of the patient in his own community by providing all pertinent knowledge of research and instrumentation to the physician practicing in that area.**

J. Plan for the evaluation of medical achievement within the regional program by established systems of evaluation such as the medical audit program (MAP) and the professional activities study (PAS).

Orthopaedists To Convene in Cleveland...

Comprehensive Course in Treatment of Fractures And Other Injuries Scheduled for Nov. 28 - Dec. 1

THE COMMITTEE ON INJURIES of the American Academy of Orthopaedic Surgeons, in conjunction with Region 6 of the Academy, and Western Reserve University School of Medicine, is presenting a program November 28 - December 1 entitled "A Comprehensive Postgraduate Course in the Treatment of Fractures and Other Injuries."

Under the direction of George E. Spencer, Jr., M. D., associate professor of orthopaedic surgery, Western Reserve, the course has been accepted for credit by the American Academy of General Practice. The place is the Hollenden House, 610 Superior Avenue, N. E., Cleveland.

The fee is $75 for other than interns or residents who present letters from their chiefs of service.

The program has been announced as follows:

MONDAY MORNING, NOV. 28

Presiding: Dr. Spencer.

Welcome: Samuel W. Banks, M. D., Chicago, chairman, Committee on Injuries, American Academy of Orthopaedic Surgeons.

Welcome: Frederick C. Robbins, M. D., Cleveland, dean, Western Reserve University School of Medicine.

Circulation of Bone in Non-Displaced Fractures, Frederick W. Rhinelander, M. D., professor of orthopaedic surgery, Western Reserve.

Plastic Surgery in Acute Trauma to Soft Tissue of Extremity, Clifford L. Kiehn, M. D., clinical professor of plastic surgery, Western Reserve.

Circulation of Bone in Displaced Fractures, Dr. Rhinelander.

Management of Open Fractures, Thomas F. Linke, M. D., assistant clinical professor in orthopaedic surgery, Western Reserve.

Anesthesia in the Injured Patient, Robert A. Hingson, M. D., professor of anesthesiology; and John G. Fraser, M. D., senior clinical instructor in anesthesiology, Western Reserve.

MONDAY AFTERNOON, NOV. 28

Presiding: J. I. Kendrick, head of the Department of Orthopaedic Surgery, Cleveland Clinic.

Epiphyseal Injuries, W. Robert Harris, M. D., associate in surgery, Toronto, Ontario, General Hospital.

Acute Chest Injuries, Harvey J. Mendelsohn, M. D., associate professor of thoracic surgery, Western Reserve.

Acute Head Injuries (Closed), Frank E. Nulsen, M. D., Harvey Huntington Brown, Jr., professor of neurosurgery, Western Reserve.

Renal Problems Related to Trauma, Robert S. Post, M. D., assistant professor of medicine, Western Reserve.

Evaluation and Management of Injuries of the G. U. Tract, Lester Persky, M. D., professor of urology, Western Reserve.

TUESDAY MORNING, NOV. 29

Presiding: John A. Murphy, M. D., assistant clinical professor of orthopaedic surgery, Western Reserve.

Audio-Visual Presentation.

Arterial Injuries — Diagnosis and Management, John H. Davis, M. D., professor of surgery, Western Reserve.

Traumatic Amputations, Herbert E. Pedersen, M. D., Detroit, professor and chairman, Department of Orthopaedic Surgery, Wayne State University.

Cardiac Injuries, Claude S. Beck, M. D., emeritus professor of cardiovascular surgery, Western Reserve.

Fractures of the Forearm (Adults), Fred P. Sage, M. D., Memphis, instructor in orthopaedic surgery, University of Tennessee.

Fractures of the Os Calcis, Nicholas J. Giannestras, M. D., chairman, Department of Fractures and Orthopaedics, Good Samaritan Hospital, Cincinnati.

TUESDAY AFTERNOON, NOV. 29

Presiding: Charles H. Herndon, M. D., Rainbow Professor of Orthopaedic Surgery, Western Reserve.

Special Panel on Multiple Injury Patients, William R. Drucker, M. D., professor and head of the Department of Surgery, Toronto General Hospital; Dr. Giannestras, Dr. Pedersen, and Dr. Sage.

WEDNESDAY MORNING, NOV. 30

Presiding: Joseph E. Brown, M. D., head of the Orthopaedic Department, St. Luke's Hospital, Cleveland.

Audio-Visual Presentation.

Fractures of the Elbow (Children), Walter P. Blount, M. D., Milwaukee, clinical professor and chairman, Department of Orthopaedic Surgery, Marquette University School of Medicine.

Fractures of the Elbow (Adults), Norman J. Rosenberg, M. D., attending orthopaedic surgeon, Mount Sinai Hospital, Cleveland.

Shoulder Separations, John C. Kennedy, M. D., associate professor of surgery, University of Western Ontario.

Fractures of the Patella, Walter A. Hoyt, Jr., M. D., chief of orthopaedic service, Akron City Hospital.

Acute Knee Injuries, Dr. Kennedy.

WEDNESDAY AFTERNOON, NOV. 30

Presiding: Sam G. Stubbins, M. D., clinical instructor in orthopaedic surgery, Western Reserve.

Fractures of the Forearm (Children), Dr. Blount.

Primary Care of the Injured Hand, George S. Phalen, M. D., associate professor of orthopaedic surgery, Cleveland Clinic Foundation.

Fractures and Dislocations of the Hand and Wrist, Elden C. Weckesser, M. D., clinical professor of surgery, Western Reserve.

Injury of the Extensor Tendons, Kingsbury G. Heiple, M. D., assistant professor of orthopaedic surgery, Western Reserve.

Injury of the Flexor Tendons, Alfred B. Swanson, M. D., chief of orthopaedic surgery, Blodgett Memorial Hospital, Grand Rapids, Mich.

THURSDAY MORNING, DEC. 1

Presiding: Rudolph S. Reich, M. D., consultant orthopaedic surgeon, Mount Sinai Hospital, Cleveland.

Audio-Visual Presentation.

Fractures and Dislocations of the Cervical Spine, J. Neill Garber, M. D., Indianapolis, professor of orthopaedic surgery, Indiana University School of Medicine.

Decompression of the Spinal Cord Following Trauma, John A. Jane, M. D., senior instructor in neurosurgery, Western Reserve.

Fractures of the Tibia, Ian MacNab, M. D., assistant in surgery, University of Toronto.

Fractures and Dislocations of the Ankle, Dr. Hoyt.

Fractures of the Femoral Neck, Dr. MacNab.

Cleveland Physician Appointed To the State Medical Board

Dr. Henry A. Crawford, of Cleveland, Immediate Past President of the Ohio State Medical Association, has been appointed a member of the State Medical Board of Ohio by Governor James A. Rhodes. He was named to complete the unexpired term of Dr. Donald F. Bowers, of Columbus, who resigned after many years of service on the Board. The term expires March 14, 1970.



Dr. Crawford

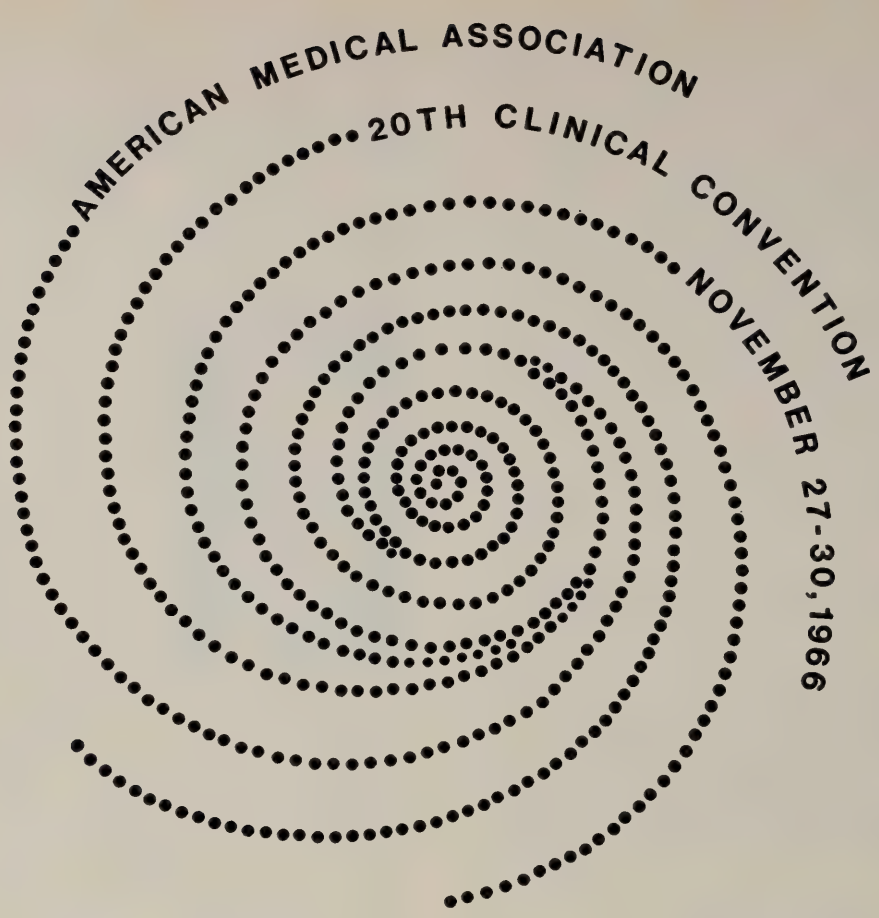
Dr. Crawford completed his year as OSMA President in May of this year and is serving an additional year on The Council as Immediate Past President. Before being named President-Elect of the State Association in 1964, he served four years as Councilor of the Fifth District. He is a graduate of Western Reserve University School of Medicine, a diplomate of the American Board of Surgery, and a Fellow of the American Proctological Society. His practice is limited to surgery and proctology.

Dr. Crawford is a Past President of the Academy of Medicine of Cleveland and Cuyahoga County and a former member of its Board of Directors. In 1961, Dr. Crawford completed 37 years of military service with the Air Force and the National Guard. From 1940 to 1946, he was on active duty.

The State Medical Board is the state agency charged with the responsibility of licensing physicians and limited practitioners in Ohio and enforcing the law as it applies to the healing arts.

Other members of the Board are the following: Domenic A. Macedonia, Steubenville, president; Mervin F. Steves, M. D., Cincinnati, vice-president; John D. Brumbaugh, M. D., Akron; J. O. Watson, D. O., Columbus; Frederick T. Merchant, M. D., Marion, who also is a member of the OSMA Council; Ralph K. Ramsayer, M. D., Canton; and Lloyd R. Evans, Columbus. William T. Washam, M. D., LL. B., Columbus, is executive secretary of the Board.

Dr. Herman K. Hellerstein, assistant professor of medicine, Western Reserve University School of Medicine, was one of five physicians named as the 16th traveling faculty of the American College of Cardiology Circuit Course to provide educational aid in several countries of Africa. Faculty members serve without compensation in the program sponsored by the Cultural Affairs Department of the U. S. State Department.



AMA '66
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Convention site "extraordinaire" that's Las Vegas. America's entertainment capital becomes the classroom for America's practicing physicians—offering you a comprehensive, compact, postgraduate course in recent developments in medical science. A magnificent Convention Center, fine hotels and motels, excellent restaurants plus star studded entertainment await you and your family.

The AMA's first clinical convention in Las Vegas offers a top notch scientific postgraduate program.

Scientific sessions will be held on the following topics: Scintillation Scanning • Radiation and Cancer • Clinical Pulmonary Physiology • Gastroenterology • Futuristic Diagnostic and Therapeutic Tools • Neck Pain • Antibiotics • Urology • Aerospace Medicine • Unconsciousness • Dermatology • Juvenile Diabetes • Endocrine and Metabolic Diseases • Pediatrics • Surgery • Hematology • Psychiatry • Otolaryngology.

Three Postgraduate Courses will be presented: Obstetrics and Gynecology • Fluid and Electrolyte Balance • Cardiovascular Disease. Each Course will consist of three half-day sessions, and there will be a registration fee of $10.00 for each course, payable with your advance registration.

Four Breakfast Round Table Conferences will be held on the following topics: The Management of Metabolic Bone Disease • Indication for Cardioversion • The Problems and Potential of L.S.D. • An Agonizing Reappraisal of Cancer Chemotherapy • **Closed Circuit Television • Medical Motion Picture Programs • Over 275 Scientific and Industrial Exhibits.**

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 24.

Support for Medical Education ...

Ohioans Again Offered Opportunity To Help Keep Medical Students and Medical Schools Independent and Solvent

OHIO's annual campaign in behalf of the Medical Education Loan Guarantee Program and the Funds for Medical Schools Program of the American Medical Association Education and Research Foundation is now underway.

Dr. Robert S. Martin, Zanesville, is Chairman of the Ohio AMA-ERF Committee, which is composed of the chairman and the 11 District Councilors of the Ohio State Medical Association.



R. S. Martin, M.D.

Since 1951, when the AMA established its Funds for Medical Schools Program, members of the profession have contributed an average of more than a million dollars a year through this channel. Four times this amount is contributed annually by physicians directly to the nation's medical schools.

Grants to Ohio's three medical schools resulting from 1965 contributions to the Funds for Medical Schools Program were: Ohio State University College of Medicine, $13,489.08; University of Cincinnati College of Medicine, $17,549.28; Western Reserve University School of Medicine, $13,196.72.

School May Be Specified

Money contributed to AMA-ERF Funds for Medical Schools may be designated for a specific school by the donor or for medical education in general. In the latter case, funds are distributed equally among the medical schools. Deans of the medical schools may use Foundation grants at their discretion for special projects or expenses outside of their budgets.

The Medical Education Loan Guarantee Program, administered by AMA-ERF, guarantees long-term bank loans to medical students, interns and residents for essential training and living expenses. Each $100 that is contributed to this Program, secures a loan of $1,250. Some 27,511 loans have been made since this Program was initiated in March, 1962, totaling $32 million.

Prior to this program's start, there was no adequate loan source readily available to medical students. In plans which were available, rates were high and deferred repayment usually could not be arranged. Now a medical trainee may borrow up to $1,500 per year over his training period to a total of $10,000. He defers repayment until five months after completion of all his full time training, and then may take ten years to repay in monthly installments. Contributions to this program may be earmarked to guarantee loans in a particular state or area.

Last Year Response Good

Last year more than half of the members of the Ohio State Medical Association made contributions to medical education, either through AMA-ERF or directly to their own schools.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Martin, members of the 1966 Ohio AMA-ERF Committee and the local chairmen urge Ohio physicians to respond generously in this year's campaign.

Cleveland Clinic Foundation Announces PG Courses

The Cleveland Clinic Educational Foundation, has announced a number of postgraduate courses of interest to physicians and allied groups.

Details on these and other activities of interest may be obtained from Walter J. Zeiter, M. D., director of education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

The following courses have been announced:

November 16 and 17 — Diagnosis and Treatment of Neuromuscular Disorders.

December 7 and 8 — Postgraduate Course in Ophthalmology.

January 11 and 12 — Advances in Dermatology.

January 18 and 19 — Controversies in General Surgery.

February 1 and 2 — General Practice.

Dr. George W. Wright, Cleveland, is a member of a national task force on the prevention and control of emphysema and chronic bronchitis. The 25-member group recently met in Princeton, New Jersey, under cosponsorship of the U. S. Public Health Service and the National Tuberculosis Association.

When thiazide or reserpine alone won't keep



Establish and maintain early, more decisive control of blood pressure

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Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

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DIUTENSEN-R is thiazide and reserpine *plus cryptenamine*—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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Outstanding Scientific Exhibit At OSMA Annual Meeting

OUTSTANDING FEATURE at the 1966 OSMA Annual Meeting in Cleveland, May 24-28, was the Scientific and Health Education Exhibit. In keeping with a policy recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for certain exhibits designated as outstanding by the judging committee. This year seven exhibits were selected to receive the special honors which included mounted and engraved plaques, certificates and monetary awards. The committee designated three exhibits in the field of teaching, and three in the field of original investigation to receive respectively the gold, silver, and bronze awards, and named a seventh exhibit to receive a special award. Following is a brief description of one of these award-winning exhibits.

Gold Award in Teaching Field Goes to "G-Suit" Exhibit

The Gold Award in the Field of Teaching at the 1966 OSMA Annual Meeting was presented to sponsors of the exhibit, entitled "Control of Bleeding by G-Suit." Sponsors were Dr. John Storer and Dr. W. James Gardner, of the Huron Road Hospital, Cleveland.

This exhibit depicted the historical development of the G-Suit and its current application in combating hypovolemic shock and controlling bleeding.

Crile, in 1903, fabricated a crude inflatable suit made of India rubber, which was used to treat shock. Its use was short lived because of his mounting interest in blood transfusion and the technical difficulties encountered with the suit. The next application of the principle of circumferential pneumatic compression was represented by the antigravity garment fabricated for use in aviation. In the early 1940's and thereafter, one investigator used this principle extensively in sustaining the blood pressure in patients operated on in the sitting position.

In 1955, as a last resort, the G-Suit was used to combat shock in a patient with uncontrollable abdominal bleeding. Surprisingly, it controlled both shock and **bleeding.** In an effort to ascertain the mechanism whereby bleeding was controlled, an experiment was undertaken. Eight mongrel dogs were anesthetized with pentobarbital sodium and a portion of their abdominal aorta occluded in a Cooley clamp. A 0.5 cm. longitudinal incision was made in the anterior wall of the aorta, the clamp released and an experimental model of the G-Suit inflated rapidly to 40 mm. Hg. Carotid pressures were monitored during the entire experiment. The G-Suit was deflated at the end of one hour. These studies consistently demonstrated the ability of the suit to sustain arterial pressures one and one-half to two and one-half times that of the G-Suit pressures. At the end of one hour, the G-Suit was deflated and all animals expired.

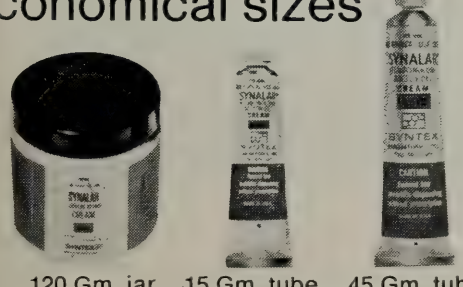
Aortograms done with the G-Suit inflated for one hour following aortic laceration depicted the aortic continuity to be intact and showed perfusion of the tissues distal to the laceration. There was no apparent escape of dye into the abdominal cavity.

The mechanism responsible for "closure" of the laceration is thought to be a manifestation of the Law of LaPlace. This ancient law states that the tangential tension on the wall of a vessel, tending to pull it apart, is proportional to the product of the hydrostatic pressure within the vessel and the radius. In this equation, R is the most important and most frequently variable factor. This explains the mechanism involved in the rupture of a balloon at its weak point. The balloon, though having a common intracavitory pressure, has greater tension on the area involving the "weak spot" and thus will break in this area. The reason for the greater tension being that this is the area of the greater radius. Circumferential pneumatic pressure decreases the radius in the instance of the lacerated vessel to the point where the incision is actually closed. It is not able to completely occlude the vessel, because in the ultimate it is compressing liquid (blood) which within the limitations of these pressures is virtually incompressible.

Certain other applications of this principle are exhibited. Its use as a splinting device for fractured extremities is well known and has come about through this investigation. As the splint is inflated, it elongates and thus is able to immobilize the extremity. In addition to its splinting property, it is able to control arterial or venous bleeding from the extremity in a manner as described above. It has also been used to act as a pressure dressing after joint operations (meniscectomy) and in the treatment of post mastectomy edema of the upper extremity.

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Obituaries

Ad Astra

William H. Caine, M. D., Antwerp; Ohio State College of Homeopathic Medicine, Columbus, 1916; aged 78; died September 24 as the result of a traffic accident; former member of the Ohio State Medical Association and the American Medical Association. Dr. Caine practiced in the Antwerp area from 1928 to 1963, after moving there from the Cleveland vicinity. He was a veteran of World War I. Surviving are his widow, a son, a daughter, and a sister.

Wilson Smith Chamberlain, M. D., East Cleveland; Western Reserve University School of Medicine, 1916; aged 78; died September 28; member of the Ohio State Medical Association and the American Medical Association. A general practitioner of long standing in Cleveland, Dr. Chamberlain was a former assistant coroner, and a medical director of the Children's Fresh Air Camp during its earlier years. A veteran of World War I, a member of the American Legion, and was affiliated with several Masonic bodies. His widow and a daughter survive.

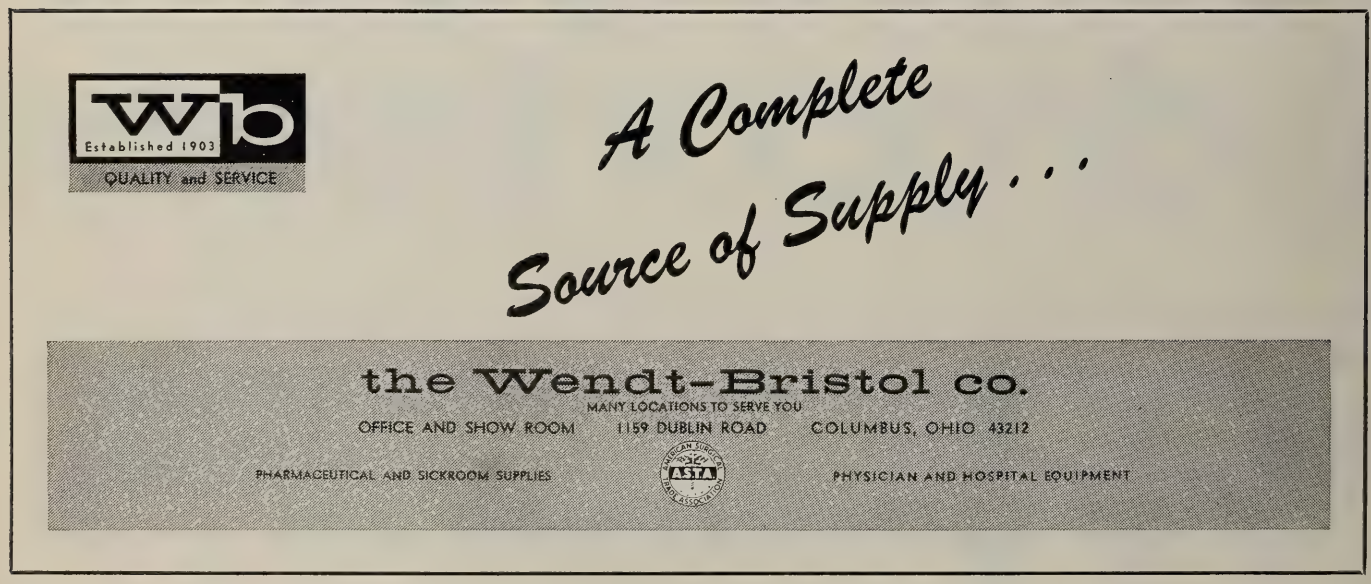
Martin Luther Crawford, M. D., Cleveland; Howard University College of Medicine, 1915; aged 75; died September 8. Dr. Crawford was a practicing physician of more than 50 years standing in the Cleveland area. During World War I, he served in the Army Medical Corps. Among survivors are his widow, a sister, and a brother.

Benjamin Fletcher Cureton, M. D., Walhonding; Starling Medical College, Columbus, 1903; aged 89; died September 19; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in the Coshocton County community, Dr. Cureton lived in retirement for a while in Mt. Vernon. He was a veteran of World War I. A sister and a brother survive.

Harry A. Duncan, M. D., Millersburg; Medico-Chiurgical College of Philadelphia, 1904; aged 89; died September 16; member of the Ohio State Medical Association and the American Medical Association. After a long practice in the Philadelphia area, and distinguished teaching career at Temple University, Dr. Duncan retired in 1951 and moved to Millersburg where he founded the Holmes County Cancer Detection Clinic at Pomerene Hospital. A native of Holmes County, a member of the local Masonic Lodge, an elder in the Presbyterian Church, and a member of the Rotary Club, he found time to write histories of these organizations. A daughter is among survivors.

Cemal M. Ergene, M. D., Bloomfield Hills, Mich.; graduate of the Medical Faculty of the University of Istanbul, Turkey, 1937; aged 50; died September 27. A native of Turkey, Dr. Ergene served for 18 years as a medical officer in the Turkish Navy before coming to this country. He was licensed in Ohio and was a former staff member at Sunny Acres Tuberculosis Hospital in Cleveland. Only recently he had accepted an appointment with the Oakland County Sanitorium, in Pontiac, Michigan. His widow and two sons survive.

John Gaston Mateer, M. D., Detroit, Mich.; Johns Hopkins University School of Medicine, 1918; aged 76; died September 3. Though a practitioner in



Detroit for most of his professional career, Dr. Mateer was well known in his native Wooster area and was a trustee of the College of Wooster. He was the son of the late Dr. Horace N. Mateer, of Wooster. Survivors include his widow, a daughter, and two sisters.

Ralph Henry Miller, M. D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 62; died September 21; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Ophthalmology. A specialist in ophthalmology in Cincinnati for 34 years, Dr. Miller was head of the ophthalmology service at Christ Hospital, and assistant professor of ophthalmology at the University of Cincinnati College of Medicine. He was a veteran of World War II, during which he served overseas. A member of the Presbyterian Church, he is survived by his widow, a son, and two daughters.

Guy Anthony Parillo, M. D., Youngstown; Wayne State University College of Medicine, 1917; aged 76; died September 14; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A general practitioner, Dr. Parillo's professional career in the Youngstown area extended over 49 years. Among affiliations, he was a member of the American Legion, as a veteran of World War I. Survivors include four brothers and two sisters.

Raymond M. Strow, M. D., Weston; Toledo Medical College, 1900; aged 90; died September 1. A practitioner in the Weston area of Wood County since 1931, Dr. Strow had previously practiced in Cygnet, West Leipsic, and Milton Center. He was a member of the Church of Christ, and of several Masonic bodies. Survivors include his son and a daughter.

VA Medical Research Conference Is Scheduled in Cincinnati

The Netherland Hilton Hotel in Cincinnati will be the scene of this year's Veterans Administration Medical Research Conference. The conference, the 17th to be held since they were first initiated in Atlanta, Georgia, in 1950, will start on Tuesday evening November 29 and run until early Thursday afternoon of December 1.

On Wednesday, the guest speaker Dr. William Stewart, surgeon general, PHS, will address the general session on the topic — "The Role of Government in Medical Research."

This year's program will feature four special lectures by VA investigators: Dr. Thomas E. Starzl, VAH, Denver, Colorado, on "The Status of Organ Transplant;" Dr. Oscar Auerbach, VAH, E. Orange, New Jersey, on "Newer Information on Emphysema;" Dr. Leonard Skeggs, VAH, Cleveland, Ohio, on "Progress with Automated Laboratory Systems;" and Dr. D. Ewen Cameron, VAH, Albany, N. Y., on "Memory in Relation to Problems of Aging."

A highlight of the meeting will be an address Wednesday afternoon by Dr. Rachmiel Levine, chairman of the Department of Medicine, N. Y. College of Medicine on the subject — "Carbohydrate Metabolism."

A series of 10 round-table discussions will take place on topics of current interest.

In view of the increasing activities and interest surrounding VA's affiliations with the Medical Schools, a program Wednesday evening will be presented by the VA Education Service.

Dr. George M. Owen, associate professor of pediatrics in Ohio State University College of Medicine, has been appointed to a second term of three years on the Committee on Nutrition, American Academy of Pediatrics.



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Activities of County Societies . . .

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

HAMILTON

The Academy of Medicine of Cincinnati held its annual meeting and first meeting of the new season on September 20, with installation of new officers as one of the main features.

Installed as president was Dr. Elmer R. Maurer, who succeeded Dr. Robert M. Woolford. Dr. Woolford remains on the Council as immediate past president. Dr. Stanley D. Simon was installed as president-elect. Other officers include Dr. John J. Will, as secretary, and Dr. Robert S. Heidt, as treasurer. Mr. Edward F. Willenborg is executive secretary.

"The Legislative Influence on Medical Practice" was the topic of discussion at the October 18 meeting of the Academy, held in the Academy's auditorium. Guest speaker for the occasion was The Honorable Gerald R. Ford, Congressman from the Fifth District of Michigan, and minority leader in the Michigan House of Representatives.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

At the regular meeting of the Lima and Allen County Academy of Medicine on September 20th 86 members and guests were present. Dr. John P. Storaasli, professor of radiation, Western Reserve University, gave a very interesting and scholarly lecture on Cancer of the Head and Neck.

Third District Councilor Frederick T. Merchant presented a Fifty-Year pin to Dr. Gail E. Miller. Dr. Miller received a standing ovation from the academy.

Dr. Thomas C. Rockwell was voted to membership in the academy. — T. D. Allison, M. D., Secretary-Treasurer.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo and Lucas County announced the following features on the October calendar:

Meeting of the Section on Pathology, October 14. Panel discussion on "Blood, Blood Fractions, and Blood Volume Studies." Participating were Drs. W. H. Hartung, moderator, Thomas Geracioti, Richard Schafer, H. Stewart Siddall, and Daniel Rigal.

Symposium and Discussion on "Executive Health and Predictive Medicine," and afternoon and evening program on October 28 sponsored by the Western Ohio Section of the Industrial Medical Association.

The Toledo Academy is looking forward to two outstanding programs. On November 10 and 11 the Inter-Hospital Postgraduate Lecture Series will be given with Dr. Sidney Gellis, chief of pediatrics at Tufts-New England Medical Center, as lecturer. The theme is "Current Problems in Pediatrics." On January 12 the Academy will hold its 65th annual meeting. Speaker will be Henry J. Taylor, syndicated columnist and lecturer who will use as his topic, "Looking Ahead at Home and Abroad."

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

CUYAHOGA

A meeting to discuss Medicare was held by the Academy of Medicine of Cleveland on September 20 in the Statler-Hilton Hotel, of Cleveland. The meeting followed a social hour and dinner.

Dr. David Fishman, president of the Academy, presided over the meeting, while Robert A. Lang, executive secretary, was moderator of the program discussion.

Included as program speakers and panel discussants were Dr. James Z. Appel, Immediate Past President of the American Medical Association; Carl D. Donfils, administrative vice-president, Medical Mutual of Cleveland; and Vernon R. Burt, executive vice-president, Blue Cross of Northeast Ohio.



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References:

[1]Morrison, A. B.; and Campbell, J. A., Journal of Pharmaceutical Sciences, 54, 1 (1965)

[2]Campagna, F. A., Cureton, G., Mirigian, R. A., and Nelson, E., ibid., 52, 605 (1963)

[3]Levy, G., and Hayes, B. A., New England Journal of Medicine; 262, 1053 (1960)

GEAUGA

Members of the Geauga County Medical Society and guests will participate in a dinner-dance recognizing the One Hundredth Anniversary of the Society. The Centennial Celebration will be held on Saturday, December 3, at the Berkshire Hills Country Club, located on Route 322, east of Chesterland.

Dr. Bruce F. Andreas, president of the Society, and a committee are making preparations for celebration of the Centennial celebration.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

The Rev. Dr. Paul B. McCleave, director of the Department of Medicine and Religion of the American Medical Association, was the speaker at the September 20 meeting of the Mahoning County Medical Society. Clergymen from Mahoning County were guests of the medical society. Dr. McCleave addressed the joint meeting on the paradoxes in modern medicine. He discussed such things as the kidney machine, the mechanical heart, organ transplants and the contraceptive pill, and the moral decisions resulting from their use.

Dr. McCleave was introduced by Dr. Jack Schreiber, program chairman. Dr. F. A. Resch, president, presided.

Seventh District

(COUNCILOR: SANFORD PRESS, M. D., STEUBENVILLE)

BELMONT

The Belmont County Medical Society, with the Auxiliary, held a late afternoon program followed by a dinner at the Belmont Hills Country Club on September 15.

Speaker for the occasion was Dr. Gregory B. Krivchenia, Wheeling, W. Va., who discussed "Athletic Injuries."

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

The Academy of Medicine of Columbus and Franklin County held a specialty society day program on September 20 in cooperation with the Neuropsychiatric Society of Central Ohio, the Columbus Society of Anesthesiologists, and the Columbus Surgical Society.

The neuropsychiatric group heard a discussion by Dr. Robert E. Litman, Los Angeles, California, entitled "Suicide Prevention — 1966."

Dr. John W. Ditzler, Detroit, Michigan, discussed the topic, "Management of Intractable Pain," before the group interested in anesthesiology.

Eleven speakers of a panel sponsored by the Columbus Surgical Society presented a discussion, "Recent Developments in Surgery," from the standpoints of the various branches of surgery.

An open house reception was held prior to the meeting at the new headquarters suite of the Academy, 17 South High Street, in downtown Columbus, after which dinner was served in the Neil House.

Eleventh Distirct

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Road

LORAIN

Thomas M. Teree, M. D., of Cleveland, was the featured speaker of the evening to a good representation of Lorain County Medical Society members when they met at Oberlin Inn on October 11. Dr. Teree is assistant professor in pediatrics at Western Reserve University School of Medicine and Assistant Pediatrician at University Hospitals of Cleveland. Since 1964 he has also been program director, NIH Clinical Research Center for Children at University Hospitals.

Speaking on Fact, Fancy, and the Future in relation to Prevention of Mental Retardation, Dr. Teree outlined the impact of technological advances in the research and care of the mentally retarded. An informative question and answer period followed and President J. A. Cicerrella accorded the speaker a warm vote of thanks on behalf of all those present.

During the business session, the following physicians were unanimously voted into Associate Membership in Lorain County Medical Society:

M. A. Amiri (Lorain): Valentine C. Marr (Avon): George P. Gotsis (Lorain): Lawrence G. Thorley (Elyria) Richard C. Wamsley (Oberlin): and Charles E. Zepp (Elyria). Unanimously elected to Active Membership were Eino Kooba of Lorain and Thomas Sfiligoj of Lorain.

A report on the Uterine Cancer Detection Project was given by A. Clair Siddall, M. D., chairman of the Cancer Committee. The program has now been in effect for six months, sponsored with funds from the Ohio Department of Health. Marion G. Fisher, M. D., Lorain County health commissioner, is co-director of the Project which also has the co-operation of the Lorain County Welfare Department, the local Chapter of the American Cancer Society, and the Outpatients' Departments of Elyria Memorial Hospital and Lorain St. Joseph's Hospital.

R. S. VanDervort, M. D., reported on the candidates up for office at the November elections, and briefly outlined their qualifications and attitudes toward the medical profession.

President Cicerrella announced the appointment of the Nominating Committee for 1967 slate of officers — Dr. John W. Wherry as chairman, Dr. John Halley and Dr. Henry E. Kleinhenz.

The Fort Steuben Academy of Medicine opened its 21st year of activity with a meeting at the Fort Steuben Hotel, Steubenville. Speaker for the occasion was Dr. Peritz Scheinberg, professor and chairman of the Department of Neurology, University of Miami School of Medicine.

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Woman's Auxiliary Highlights . . .

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BACK IN AUGUST, Mrs. John B. Hazard, chairman of the state membership committee, sent out to county chairmen what I consider an outstanding and informative letter, full of practical workable suggestions. After all, every auxiliary member is, in effect, part of any county's membership committee and I think it's a good idea for each such member to read Mrs. Hazard's letter and digest it:

"In this era of antibiotic chemotherapy, preventive vaccines, dramatic transplants and artificial replacements, surely there must be some therapy to help 'close the gap' between the potential and present membership of the Ohio State Auxiliary. Your state chairman does not have the answer, but since a number of our Ohio counties have obtained 100 per cent membership and many are within reach of this goal, I am going to share with you some of the methods they have found successful. The following suggestions came from reports of county membership chairmen for 1965-66:

"Have a standing invitation to be mailed to wives of all doctors as soon as they become members of the medical society; enclose a calendar of events. Use the positive approach — personal contact. Have a hostess group at each meeting. When possible, have a new member brought to a meeting by a committee member and introduced. Have a courtesy committee to keep informed as to members having babies, being hospitalized and those with deaths and illness in the family. Keep a file card for each member with year of joining, professional background, hobbies, interest, positions held in other organizations and a record of auxiliary service; use this file to fit members to specific jobs and try to give everyone a job or have them participate in some way. Make a personal visit to new M. D.'s family — take an auxiliary booklet, the News, or any local auxiliary information. Plan an orientation for new members.

"Retrieve members by a personal call; if a grievance, try to correct it. Plan an evening meeting to encourage young mothers. Devise a distinctive name tag for new members to wear throughout the year to enable senior members to recognize them and make a special effort to welcome (particularly among large membership groups). On one meeting day have "coffees" in different areas for new and old members with a board member present at each coffee to give information and answer questions (again more practical among large membership).

"Yours is a challenging job and the three challenges you should try to meet are: To sign up the new doctor's wife before other groups attract her; to win over established doctors' wives who have never joined; and to get the drop-outs back in the fold. Promote the joint husband-wife membership. Discuss the plan with your advisors and get the approval of your medical society. If you would like to have more information regarding the 100 per cent husband-wife team membership, let me know . . ."

Mrs. Hazard wants to give every county auxiliary all possible help. She is at your service, just for the asking. (Box 171, County Line Road, Gates Mills, Ohio 44040.)

On the Local Scenes

Belmont County auxiliary held its annual Bittersweet Ball on October 15 at the Belmont Hills Country Club. Johnny Olszowy's orchestra furnished

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"Around the World"

A new idea in auxiliary luncheons is being promoted by the **Lucas** County group. That idea is the "Around the World in Foods" and each luncheon will feature foods from a particular country. The starting point? Why good old American cooking, of course! That "theme" prevailed at the September luncheon at which Dr. Bryan Sutton-Smith, professor of psychology at Bowling Green State University, discussed "Once Upon a Time."

Mrs. Joseph Roshe, study groups chairman, has reported an excellent response for this year. September saw the beginning sessions of these groups: French (for beginners and for continuing in conversational French); conversational Spanish; beauty through Ballet; bridge; tennis; protocol and parliamentary procedure; antiques and art; gourmet group.

"Come Alive! Don't Be a Sleeping Generation" was the topic chosen by Mrs. Harry L. Fry, state legislation chairman, for her talk before the **Scioto** County auxiliary at its September luncheon at Harold's Restaurant. Hostesses for the meeting included Mrs. B. U. Howland, Mrs. Jack MacDonald and Mrs. Ralph W. Lewis.

The **Trumbull** County group has organized a Future Doctors' Club for high school juniors and seniors interested in the medical profession. Purpose of the newly organized club is to acquaint these students with (1) the medical profession; (2) medical school requirements; (3) possibilities of financial help; and (4) other related questions. Also invited to participate are science teachers and area counselors who are interested. Six meetings have been schduled, the first of which was held on Monday, October 17, in the Trumbull Memorial Hospital auditorium. Mrs. D. S. Hall is general chairman of the Future Doctors' Club project.

"The Horse and Buggy Days of Medicine" were discussed at the September luncheon meeting of the **Washington** County auxiliary held at the home of Mrs. Ford Eddy. Mrs. Asia Whitacre, Mrs. I. J. Johnson and Mrs. E. W. Hill, Jr. were the narrators. Mrs. Richard Hille, president, welcome two new members: Mrs. Tom D. Halliday and Mrs. Leo Banuelos.

Fall Conference

It's been here (October 11 and 12) and it's gone — but "the melody lingers on" as it should, for all the coming months. What those of you who attended heard at this meeting is no idle chatter; it is information carefully worked out and evaluated after considerable study and thought by your State Board. Everything done at Fall Conference was geared to one purpose: to HELP each and every county auxiliary, big or small. I've said this before and I say it again: every state officer and every state chairman stands ready to serve you. All you have to do is ASK.

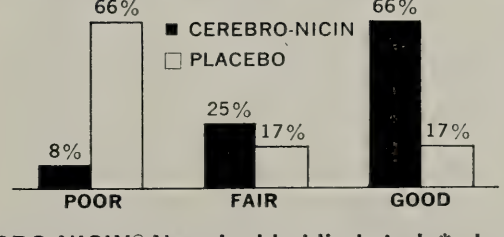
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The
OHIO STATE MEDICAL
Journal

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1294 Maternal Health in Ohio: Maternal Deaths Involving Suicide. By the OSMA Committee on Maternal Health.

1254 The Historian's Notebook: Health Officers of Cincinnati, Ohio, and the Problems of Their Day — 1900 to 1960. (Part VI.) Kenneth I. E. Macleod, M. D. Cincinnati.

Prospective scientific contributors are urged to write for instructions before submitting manuscripts.

SPECIAL FEATURE

1238 Public Health in Ohio

NEWS AND ORGANIZATION SECTION

1296 Proceedings of The Council, Special Sessions

1305 Notice to All Members Regarding Payment of Dues

1307 Joint Committee Moves to Combat Athletic Injuries

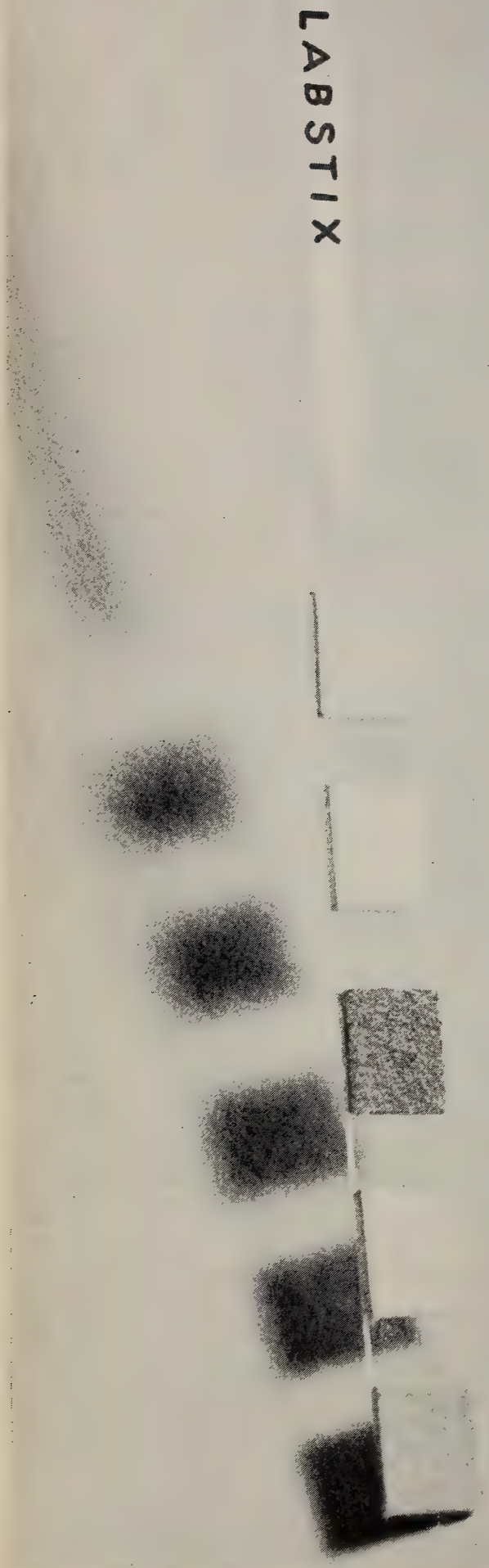
1308 Institute on Areawide Planning Scheduled January 15

(Continued on Page 1340)

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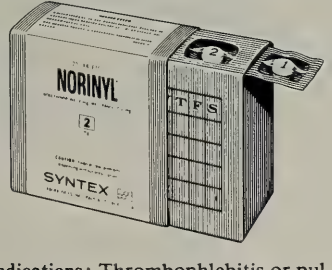
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Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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Public Health in Ohio . . .

Expansion of Facilities and Services Is Theme of Talk By State Director Before Ohio's Health Commissioners

A JOINT MEETING was held in Columbus, September 14-16, comprising the 47th annual conference of the Ohio Health Commissioners with the Ohio Department of Health, and the 6th annual meeting of the Association of Ohio Health Commissioners.

One of the principal speakers at the joint conference was Dr. Lawrence C. Meredith, Elyria, President of the Ohio State Medical Association, who discussed matters of common interest to the medical profession and to health commissioners and health personnel.

Dr. John E. Reed, Cincinnati, health commissioner for Hamilton County, was installed as president of the Association of Ohio Health Commissioners, to succeed Dr. Robert A. Vogel, of Dayton, who remains on the executive committee as immediate past president. Dr. Ollie Goodloe, Columbus health commissioner, was named president-elect, and Robert McConaughy, of Middletown, was elected secretary-treasurer. E. A. Graber, Columbus, is executive secretary.

A matter of much concern and one discussed in detail by a panel was recruitment of health commissioners for local districts in Ohio. Qualified health commissioners are desperately needed in several areas, as are trained persons in the various fields of public health.

Other matters of prime concern were licensure and certification of institutions, fiscal procedures, and development of alcoholism programs in the state.

Dr. Emmett W. Arnold, director of the Ohio Department of Health, presented an annual report of his department's program, an account that gives an excellent overall picture of health activities in Ohio.

Following are excerpts from Dr. Arnold's report:

Expansion

"The report of our Department to you this year has one key word in it, which will be repeated again and again," Dr. Arnold said. "That word is 'expansion.' The work of the State Health Department is expanding. The work of local health departments is expanding. The responsibilities of health departments are expanding."

"This expansion has been steady over the last few years. It has been particularly sharp in the past year. The prospect is for even more accelerated expansion in public health programs in the years just ahead of us."

We could start this overview of public health at any point in our many programs and find the same signs of growth. I was struck by the overall significance in this situation by the opening statement in a report recently submitted to me by the Chief of the Division of Nursing in our Department.

Dr. Arnold illustrated his point with a quote from a report by the chief: "We have found ourselves confronted with expanding health programs needing quality nursing services, new technicians, new disciplines, new equipment, paper work and an explosion of facts, but through all this there have emerged some new health services, some new methods of delivering nursing care to patients in their homes, and we believe many citizens of Ohio have better opportunities for more healthful living today than last year."

Nursing Program

The nurses report showed that the amount of time given to assistance of local health jurisdictions in the first half of 1966 has tripled in comparison with a similar period in 1965. The nursing staff was increased, particularly in connection with special projects in such fields as maternal and child health, tuberculosis control, migrant labor, and health insurance programs.

The 1966 Nurse Census shows 1,531 public health nurses now employed in Ohio, either full time or part time, by official health departments, boards of education, and voluntary agencies. The need for public health nurses is ascending rapidly. The department is doing what it can to help fill this need by programs of training, re-training and refresher courses for nurses who would like to help in this critical period of expansion.

Laboratory Services

The Bureau of Laboratories reports expansion in many fields — including encephalitis surveillance, streptococcus culturing for prevention of rheumatic heart disease, blood sugar analysis for diabetes detection, phenylketonuria (PKU) testing, determination of radionuclides, determination of pesticides, air

(Continued on page 1240)

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and water pollution analyses, and survey of independent laboratories for the new Medicare program.

The laboratory is running approximately 4,500 tests every week in the expanded PKU program. One hundred and eighty-eight hospitals sent specimens in August. The department purchased a second autoanalyzer for the expanding diabetes surveys, and is arranging to place fluorescent microscope equipment in all branch laboratories to help speed streptococcus determination and provide more quickly for the application of antibiotic therapy for the prevention of rheumatic fever and possible heart damage.

With respect to radionuclide determinations equipment has been added to make tests for strontium 89 and strontium 90 in milk. This places the laboratory on a comparable level of attainment with laboratories of the U. S. Public Health Service. In all, radiological health programs have been doubled in size.

The department is now running regular analysis of high volume air samples from 27 air sampling stations throughout the state, and running monthly checks for changes in chemical composition on 13 major streams at 20 different locations.

The division of Engineering during the past three years has approved plans for more than $200 million worth of sewerage and municipal waste treatment facilities, a jump of 25 per cent from the previous three years. The Water Pollution Control Board has lined up a program calling for an additional billion dollars worth of water pollution control improvements in the next four years.

Pollution Control

The Ohio Water Pollution Control Board began holding a series of public hearings this summer in connection with the federal program for establishment of water quality criteria for interstate waterways.

Interest in both air and water pollution control is growing. The Ohio Legislative Service Commission has been holding a series of hearings on both subjects.

Congress recognized the solid waste problem by passage of the Solid Waste Disposal Act which became effective last October. And the Public Health Service set up a new Office of Solid Wastes. Recently the Ohio Department was given a special grant under this act for the development of statewide planning on the solid waste problem. This is to be at least a three-year project, with the planning grant reaching $150,000 over the three years.

Maternal and Child Health

Still on the subject of expansion, programs of the Division of Maternal and Child Health have been expanded more than 2½ times in the past 3½ years. Distribution of pharmaceuticals, such as those used in controlling rheumatic fever in children, is up 78 per cent.

Tuberculosis hospitals that are needed in today's fight against tuberculosis have been officially designated. (See October issue, page 1072.)

A very much intensified tuberculosis control project is now under way in five of the largest cities — Cleveland, Cincinnati, Columbus, Dayton, and Toledo. Budgets for this program, supported by federal grants, have now been projected through 1969, and reach a total for that period of $1,392,000. It is possible that this project, started in 1964, may be carried over a ten-year period.

Big emphasis in this project is on the unhospitalized or posthospitalized tuberculosis cases. The second priority is to the inactive cases where there has been active tuberculosis within the last five years.

New Ohio legislation on tuberculosis, passed last year, in addition to providing for the increased subsidy and official designation of needed hospitals, also requires the establishment of tuberculosis registries in each county. This program is moving along well, and to date 76 of the 88 counties have established such registries or record bureaus.

Tuberculosis Control

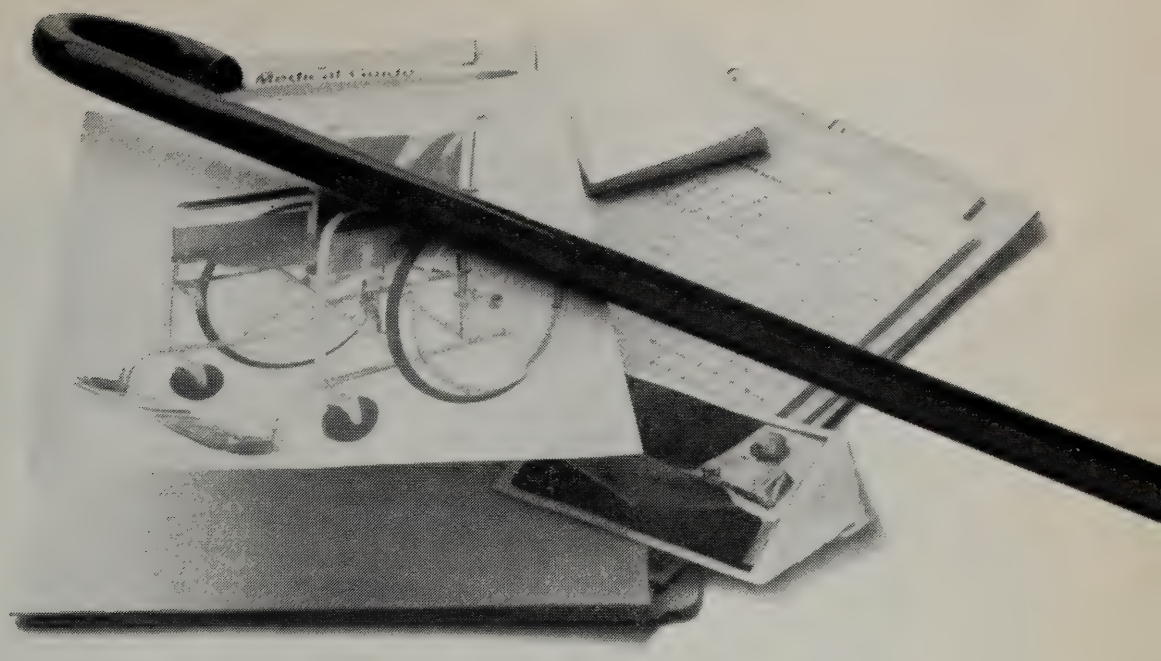
The new Ohio law on tuberculosis also encourages the creation of more tuberculosis clinics for detection and follow-up care by authorizing county commissioners of two or more counties to establish joint clinics. This law also authorizes counties to contract for such clinic services with a county or district tuberculosis hospital or with the State Director of Health.

Another new point of emphasis in our tuberculosis program is in the schools. There are two reasons for this. First, in Ohio recently there have been several unfortunate outbreaks of tuberculosis related to school environments. Secondly, tuberculin testing of school children is one of the procedures recommended by the Surgeon General's Task Force on Tuberculosis, as part of a community program for identifying persons and families at risk. The department has had full cooperation of the Ohio Department of Education in distributing to all Ohio schools a recommended tuberculosis control program. This includes tuberculin testing of all school enterers, with a follow-up of reactors and their families by local public health authorities. Pupils are to be tuberculin tested again at 14 years of age, with x-ray examination for reactors and annual chest x-rays thereafter so long as these reactors remain in school. It is suggested that schools in areas of high tuberculosis incidence may want to expand on this.

The Department has been able to increase special public health grants to Ohio from about $9 million a year to over $20 million a year during the past three years. Categorical grants at the same time have jumped from $2.5 million to $4.2 million a year.

Special health projects for expectant mothers, infants, pre-school and school-age children have been

(Continued on page 1242)



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Niacinamide	100 mg
Calcium Pantothenate	20 mg

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developed, amounting to $2.8 million in the last two years in Cleveland, $990,000 this year in Cincinnati, over $1 million this year in Columbus, and $650,000 authorized just last month in Dayton. These projects are in association with local hospitals and health agencies.

Hill-Burton Program

Ohio is joining the nation in commemorating the 20th anniversary of the Hill-Burton program. Since its inception in 1946, this program — coauthored by an Ohioan, the late Senator Harold Burton of Cleveland, has been a prime example of effective cooperative effort among agencies of federal, state, and local governments. Ohio has received a total of $111 million in grants under this law, more than $30 million in the last three years alone, which has assisted in the construction of $407 million worth of additional health facilities in 105 different Ohio communities. Included have been 23 grants to health departments for health centers. Currently health department construction projects with Hill-Burton aid are under way or about to start in Akron, Springfield, Cincinnati, Cleveland, Fremont, Lorain County, and Defiance County.

The Ohio Department of Health has been awarded a special grant under this research and demonstration program for a two-year study of the feasibility of centralizing health planning information in Ohio.

The amount of money expended by local health departments, city and county, in Ohio during fiscal 1966 was $17,486,395 — an increase of about four per cent over the $16 million of the previous year. Included in this amount was $420,000 of state subsidy and $1,173,420 distributed by the State Health Department from federal formula grants. As in past years the Department will publish a complete financial report on local health departments for 1966, to be distributed in early 1967.

Many new programs will call for larger expenditures in the years immediately ahead of us — and that new funds will become available. Part of these new funds will be in new types of grants. Part will be in new types of fees, as for example those in connection with the home health services for which Medicare will pay.

In the Ohio Department of Health an entire new unit has been created for the new programs which are essential in the implementation of the federal Medicare program, involving the certification of hospitals, laboratories, home health service agencies and extended care facilities. The department is reimbursed in full by the Social Security Administration for costs in this field.

Work in connection with migrant farm labor has been tripled.

This year saw the implementation of the new uniform milk program in Ohio. Although the licensing and inspection portions of this law have been effective only since July 1, it appears that the health departments of the state have made the transition from the "old" to the "new" very smoothly. This is not a mandatory program on local departments but rather is carried out by those departments desiring to do so.

Chronic Disease

Turning to programs in chronic diseases, it is noteworthy that interest is growing steadily in community diabetes detection screening services. From July 1, 1965, through June 30, 1966, more than 35,000 Ohio citizens were checked in these screening activities. To date, 259 previously unknown diabetics have been found — and it is expected that this number will be larger as private physician follow-up procedures are completed. During 1966, diabetes screening programs, with cooperative state and local participation, have been conducted in Adams and Brown Counties, Ashland City and Ashland County, Muskingum County and Zanesville City, Athens, Hocking, and Vinton Counties, the Cities of Painesville and Martins Ferry, Medina County, Clark County, Erie County and the City of Sandusky. Scheduled yet this fall are diabetes detection surveys in Oberlin and Amherst Cities, Darke and Preble Counties, Lucas County, Gallia County and Franklin County.

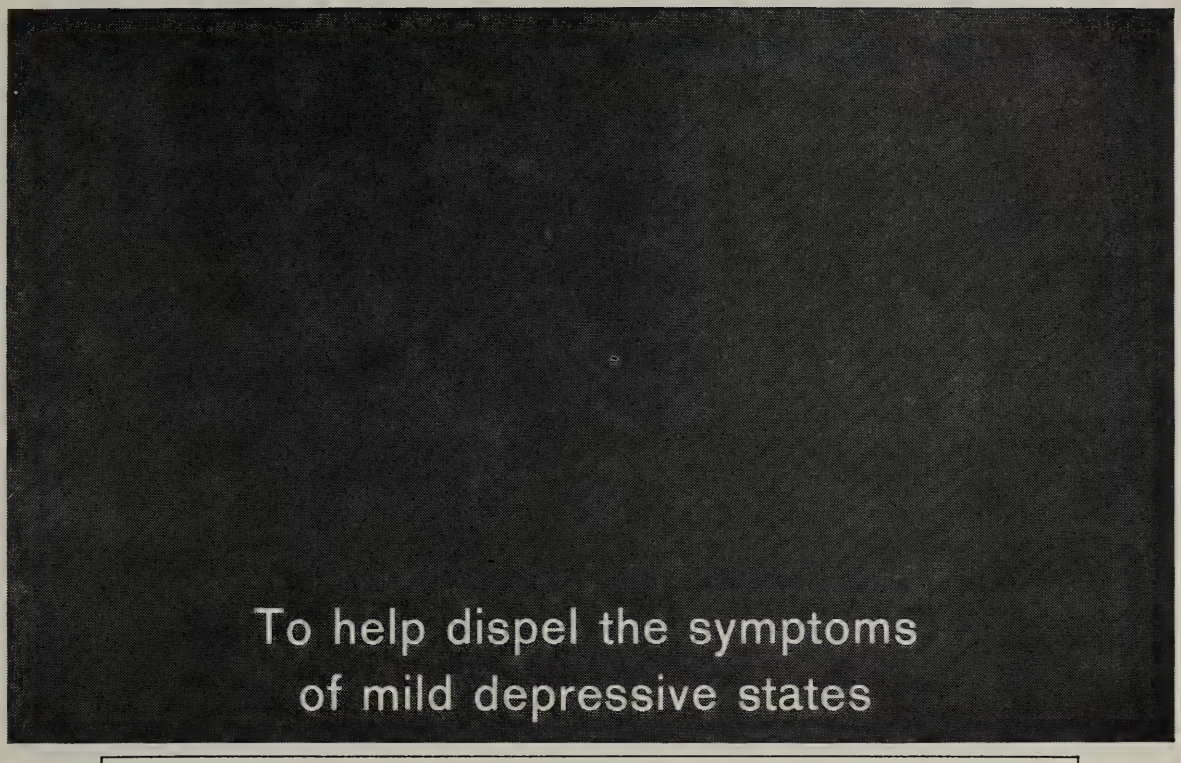
Cancer control activities have received a boost by the addition of a cancer medical officer assigned to the Ohio Department from the U. S. Public Health Service, Dr. Bernard B. Foster. Currently projects in cervical cancer detection in Columbiana County, Lorain County and Ashtabula City are supported by the department.

In connection with heart disease, the Ohio Department of Health has arranged through local health departments to make available free throat culture services for physicians in an attempt to reduce the incidence of rheumatic fever.

The department has added new screening armamentation to help in detection of early cases of obstructive lung disease. A course in closed-chest cardiopulmonary resuscitation for physicians is now under way in six cities with the cooperation of local health departments and local heart associations.

In cooperation with federal grant programs, the department is supporting more than 50 pilot demonstration projects around the state in various types of chronic disease programs. These include such approaches as continuing chronic illness community services, congestive heart failure nursing services, strep throat culture rapid identification, breathing clinic for chronic obstructive lung disease patients, child health study of obesity in relationship to heart disease, special training for public health nurses in care of cardiac patients, education on cigaret smoking as a health hazard, a public health outpatient

(Continued on page 1244)



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The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR.*

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

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diagnostic clinic, and public health nurse training in rehabilitation.

A new research and service project, which began in June in cooperation with Ohio State University and designed to serve an area within a 60-mile radius of Columbus, is a field service in speech and language for aphasics.

Alcoholism Program

In the Alcoholism Program, the last session of the Ohio Legislature gave a positive method for financing grant-in-aid projects, by providing the equivalent of one per cent of liquor permit fees for this purpose. This is expected to total close to $100,000 a year. Since the first of this year, the department has approved 17 grants to assist local alcoholism programs under this legislation.

Expansion again is the word in reference to programs of the Dental Division.

Moving along well is the new Health Referral Service to assist Armed Forces rejectees in obtaining medical care for remediable defects. Eighty of our 88 counties have joined in this program since it was started nine months ago, and approximately 95 per cent of the population of Ohio is now covered.

The Division of Occupational Health reports that the concept of health maintenance in industry is being implemented.

The decennial revision of the U. S. Standard Birth, Deaths, and Fetal Death Certificates has been completed. Revised certificates have been promulgated by the Surgeon General and will be available for use beginning January 1, 1968. During the coming year the department is planning a series of at least seven regional meetings for acquainting health department and hospital personnel with the revisions.

Regulations comprising the Ohio Sanitary Code have been renumbered and retyped for filing with the Secretary of State under the uniform system required by enactment of Section 119.04 of the Revised Code and the regulations promulgated by the Secretary of State. The renumbered regulations will be published shortly after the first of the year. In the meantime, any court action started after September 30 must be taken under the revised numbers.

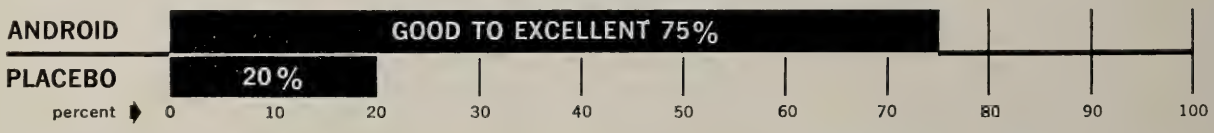
On the subject of regulations, the Ohio Public Health Council since our last annual meeting adopted a revision in nursing home regulations. Progress has been made in implementing these new regulations, resulting now in the permanent licensing of 1,082 nursing homes, which will be checked regularly.

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3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted.
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

CONTRAINDICATIONS — Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease, hyperthyroidism. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

CAUTION: Federal law prohibits dispensing without prescription.

***"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.**

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Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
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ANDROID-X NEW
Each orange tablet contains:
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Thyroid Ext. (1 gr.) 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 or 2 tablets daily.
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ANDROID-PLUS
Each white tablet contains:
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Thyroid Ext. (¼ gr.) 15 mg.
Thiamine HCL 25 mg.
Ascorbic Acid (Vit. C) 250 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
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Motorcycle Driver Risk Is Twice That of Automobile Driver

The death rate for motorcycle accidents, in relation to the number of motorcycles in this country, is twice as high as the comparable rate for automobiles and other motor vehicles.

This fact, along with other information about motorcycle injuries, is contained in a new leaflet published by the Public Health Service's Division of Accident Prevention.

"Motorcycle registrations in the United States now total more than 1½ million," said Dr. Paul Joliet, Chief of the Division. "By 1970, registrations are expected to increase one million a year. This leaflet explains, briefly, why motorcycle injuries are a serious national health problem."

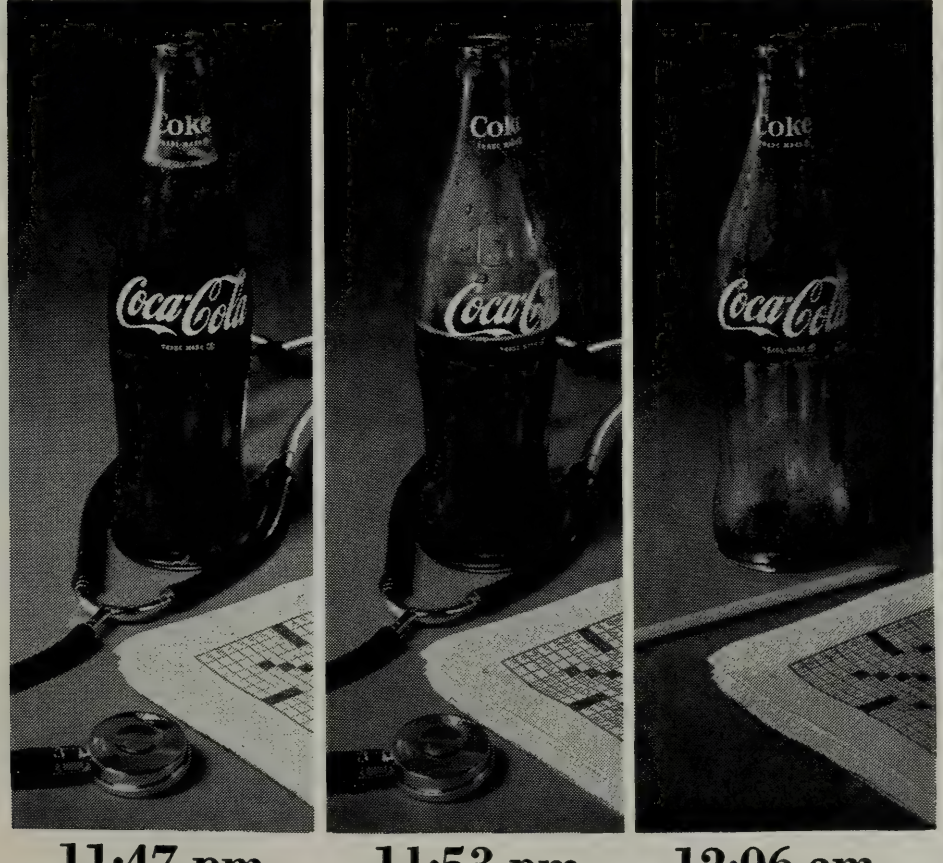
Information in the leaflet includes the following:

Many motorcyclists are often killed and injured because: (1) they lacked adequate training and experience in controlling their vehicles; (2) they failed to wear safety helmets and goggles; (3) their motorcycles lacked such safety equipment as crash bars, cowlings, and windshields; and (4) pedestrians and operators of other motor vehicles sometimes create potential accident situations by refusing to share the roadway with motorcycle riders.

One study in this country found 20 per cent of the injured persons were riding the motorcycle for the first or second time, while 70 per cent had either rented or borrowed the motorcycle.

Dr. Gregory G. Young, former chief of the Department of Neuropsychiatry at Miami Valley Hospital, Dayton, was principal speaker at the November hospital breakfast for physicians and clergy. His subject was "Care of the Psychiatric In-Patient and the Role of the Psychiatrist, Referring Physician, and Clergy."

Dr. Ralph C. Schwarz, Cincinnati, shared the rostrum with the Rev. Edward B. Brueggerman, chairman of the Theology Department at Xavier University, at a meeting sponsored by the Newman Forum on the Miami University campus, Oxford. The topic was "Abortion: A Medical and Theological Discussion."



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DIUTENSEN-R is thiazide and reserpine *plus cryptenamine*—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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The Historian's Notebook

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M. D., M. P. H.*

PART VI

(Continued from November Issue)

MEDICAL EDUCATION: Regarding the University of Cincinnati's Medical College, Dr. W. H. Peters in 1920 writes:

The Medical College educates physicians and nurses for the service of the people of Cincinnati. There are in Cincinnati at present, over 500 physicians who were educated in this college. The staff of the college and hospital does all of the work of the General Hospital. The supply of physicians is running short in the country. The medical students now number 224 from practically all the states and from six foreign countries. Many more are applying, and with our present magnificent equipment, buildings, and laboratories, double this number could be educated here. But it will be impossible to do this unless money is also provided . . .

Cincinnati General Hospital

And in a footnote on the General Hospital he notes that it is,

One of the finest in the United States; probably as can be found anywhere in the world. A rather striking feature is presented in the fact that the indigent citizen is able to receive attention that the average taxpayer is unable to afford in his home. Special pavilions are provided for communicable diseases. Also, the tuberculosis hospital is doing valuable work in limiting the spread of the Great White Plague. Under ideal conditions, tuberculosis can be treated in the home. The trouble lies in the fact that these ideal conditions are seldom found. Tuberculosis running through families for several generations is the result of the environment and conditions in the homes of these families. A wider knowledge of home sanitation will help . . .

And he notes an aphorism by the late Dr. Landis: "No sanitary problem was ever solved by caring for its victims . . ."

The continued development of "reasonable sanitary codes" is illustrated by the "new" regulations to govern the manufacture and sale of ice cream. (1920)

Mothers of Democracy and Other Matters

And "Hail to the 'Mothers of Democracy' who formed a rehabilitation society of about 500 women to dedicate themselves to deeds of charity and beneficence among the unfortunate . . ."

On the childhood diseases, Dr. Peters notes the following toll in mortality:

1920	Cases	Deaths
Measles	4,156	71
Diphtheria	258	22
Scarlet Fever	1,404	22
Typhoid Fever	19	5
Whooping Cough	287	11
Cerebrospinal Meningitis	1	1

Health Board Wins a Case

And on the *Health Board Wins An Important Decision:* It transpired that a certain William P. Devon, a wealthy tenement owner, refused "to abolish toilets of the catch-basin type." In his opinion, Judge Stabley Mathews "upheld the sections of the city ordinances, the right of the municipality to enact the same, the power of the Board of Health to enforce them, and he also held that catch-basin toilets are a nuisance."

Sex Education

A rather remarkable poster on "Health Womanhood" was published in the October issue of the Bulletin, proposing to warn the public about the dangers of VD. Truly the new frankness about these social diseases was beginning to see the real light of day . . . Sex education is discussed.

Compulsory Vaccination Upheld

The December issue of the SANITARY BULLETIN has as its frontispiece the seal sale's stamp for 1920 — a happy child on the shoulders of a smiling Santa. Its main article has the caption: "COMPULSORY VACCINATION UPHELD" and deals with an opinion of the city solicitor on the subject in reply to a question by the school superintendent, Mr. Randall J. Condon.

Prenatal Care

On prenatal care we are advised that

While Cincinnati occupies an excellent position in the Statistical Report of Infant Mortality, we feel more can be done to reduce the number of deaths in children under one

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.
Submitted March 16, 1966.



the mid-rift!

Our population's bursting at the seams.

It's eat. Eat. Eat.

And then diet. Diet. Diet.

With the latest No-calorie.
No carbohydrate. No-vitamin. No exercise.
400-hour Kamikaze Plan!

When it's over, it's eat, eat, eat again.

As a professional you can help wrest some sense from this nonsense: first, by cautioning against skipping meals, and second by pointing the way to realistic weight control through nourishing meals every day. Day after day.

Naturally, balanced diets and nourishing, palatable dairy foods go together; they always have.

Project Weight Watch has been initiated to assist you. Its scope is nationwide, its purpose is to focus professional attention on the problem.

To help you translate your concern to your patients, a portfolio of materials is available. Send for it. Help stamp out needless waist.

Dairy Councils of Cleveland, Columbus & Stark County District

1652 West Fifth Avenue Columbus, Ohio 43212

PROJECT WEIGHT WATCH

year. Last year 710 children died before they reached the first milestone, giving us a rate of 88 per 1,000 births recorded.

Crippled Children

A school for crippled children — a plan long in conception —

began to crystallize and definitely shapen about five years ago. In our own city it is proposed to increase the facilities of the care of these children by the erection of suitable buildings on the grounds of General Hospital. [A school was already in existence at the hospital.] The Board of Education in Cincinnati is enabled to carry on the work of educating the handicapped child by aid of a state subsidy. In conservation of vision classes, we take occasion to record our grateful acknowledgment of Dr. Louis Sticker's report of the blind and conservation of vision classes in our schools. The splendid results achieved in the careful correction of optical defects, the methods by which conservation is consummated to a high degree, and the scientific management of education and vocational training of the totally blind, are worthy of our highest praise . . .

And on child health in general he quotes from Herbert Hoover, President-Elect of the American Child Hygiene Association: "If we could grapple with the whole child situation for one generation, our public health, our economic efficiency, the moral character, sanity and stability of our people would advance three generations . . ."

It is noted in 1921 that a survey of the "free" day nurseries revealed that "most of the nurseries were being conducted in a very practical and efficient manner."

"Doc" Behrer Appointed Lab Chief

On page 9, etc. of the CINCINNATI SANITARY BULLETIN for March, 1921, we find an extensive discussion of the services of the Division of Laboratories by our own inimitable "Doc" Otto Behrer, Chemist and Bacteriologist in the Department for over 40 years. There were some 27,280 examinations made at a unit cost of 22 cents per test that year.

12th Street Health Center and Lab

The 12th Street Health Center's value is discussed extensively in the issue for April and we are reminded that "the nucleus of our health center was the tuberculosis dispensary, which was graciously turned over to us just a little over a year ago by the directors of the Anti-Tuberculosis League . . ." Also, "the very notable decrease in the mortality from tuberculosis in the year 1920 is noted. From 756 deaths in 1919 (a rate of 188 per 100,000 population) to 619 deaths in 1920 (a rate of 154 per 100,000)." Today (1964) the rate is about 9 deaths per 100,000.

Maternal Mortality

But in the same era — the early 1920's — a higher maternal mortality concerned the health authorities throughout the nation. It is noted as "an unfavorable trend of mortality from the puerperal diseases . . ." Dr. Peters notes, however, that

We may well be proud of our obstetric service in Cincinnati, our supervision of midwifery and the modest beginning which official and private health agencies have made in providing prenatal service, but the hope of our problem here lies in the extension of maternity nursing work.

Sleeping Sickness

The national concern with the "sleeping sickness" — encephalitis lethargica — is also a concern of Cincinnati, with

the first case reported on January 9, 1921, although four deaths were reported in December, 1920. From January to April, 36 cases were reported — the distribution scattered throughout the city. The disease attacked 24 males of whom 6 died, and 12 females of whom 9 died. There was a considerable number of complications in the survivors, mainly of a neurological nature. And as a result of this the city got into a "fight against mosquitoes." . . .

Occupational Diseases

The following "occupational diseases" were reported during the period July, 1920 — May, 1921:

	Cases
Aniline Dye Poisoning	20
Lead Poisoning	21
Zinc Poisoning	3
Occupational Neuroses	2
Chronic Dermatitis	1
Brass Poisoning	1
Total	48

Neighborhood Clinics

The concept of "neighborhood clinics" was obviously not new. In 1921 there were no less than nine "health stations" for infant welfare.

Mental Hygiene Survey

Upon the invitation of the Public Health Federation in cooperation with other agencies in Cincinnati, the National Committee for Mental Hygiene has begun a survey of Cincinnati and Hamilton County — a mental hygiene study of the public school children included. A careful physical and mental examination will be made on 10,000 children. One of the largest problems facing a state is mental defect.

Immunizations Against Diphtheria

And on diphtheria immunization, Dr. Peters writes in July, 1921:

After a year's propaganda among the people conerning the great value of permanent immunization against diphtheria by toxin-antitoxin method, we started the work. We received the cordial support and aid of the Pediatric Department of the University.

Chiropraxis

And on chiropraxis, he writes:

In a masterly manner, Justice Wanamaker has handed down his decision dissolving the temporary injunction obtained by the chiropractors of the State of Ohio against the administration of the Platt-Ellis Law and Talley Law, which prescribe the qualification for all who would treat the sick. Public health is the very heart of public happiness. The constitutional guarantees of life, liberty, and the pursuit of happiness are of little avail unless there be clearly implied therefrom the further guarantee of safeguarding the public health . . . (So said the judge among other things.)

(Continued in January Issue)

Dieting Results Shown in Anti-Coronary Club

A substantial decrease in coronary heart disease is reported among New York men who modified their diet for five years as members of an Anti-Coronary Club.

The report appeared in the November 7 *Journal of the American Medical Association.*

The incidence of "coronary events" among 814 volunteers, 40 to 59 years old, was only a third as great as that among a control group of 463 men of the same age.

Significant reductions in obesity and hypertension also were noted among the study group. These conditions remained unchanged in those who did not use the special diet.

The study was designed to test the hypothesis that reducing serum cholesterol in the diet will reduce coronary heart disease. This was done by designing a "prudent diet" that cut intake of saturated dietary fats. The project has been conducted since 1957 by the Bureau of Nutrition of the New York City Department of Health.

Much further study needs to be done, the investigators point out, because the amount of new heart disease among groups of this size is relatively small. Follow-up studies also are needed on the men who have experienced various kinds of heart malfunctions.

Among men aged 40 to 49 who used the special diet for five years, there was a heart-disease incidence rate of 339 per 100,000 years, compared to 642 per 100,000 among the non-dieters.

In the 50 to 59 age group, the rates were 379 per 100,000 among dieters and 1,331 per 100,000 in the control group.

Controversies in General Surgery Is Topic At Cleveland Clinic

The Cleveland Clinic Educational Foundation is offering a postgraduate course entitled "Controversies in General Surgery" on Wednesday and Thursday, January 18 and 19.

Guest speakers will include the following:

Dr. Bentley P. Colcock, Department of Surgery, Lahey Clinic Foundation, Boston;

Dr. Jerome A. Urban, associate clinical professor of surgery, Cornell University Medical College, New York; and

Dr. Claude E. Welch, associate clinical professor of surgery, Harvard Medical School, Boston.

A number of members of the clinic staff also will participate in the program.

Registration may be made, or information obtained from Walter J. Zeiter, M. D., Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106. Registion fee is $40.

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vignettes of angina pectoris—
no. 1 in a series:

angina and the surgeon

John Hunter—
British surgeon (1728-1793)

angina of anger

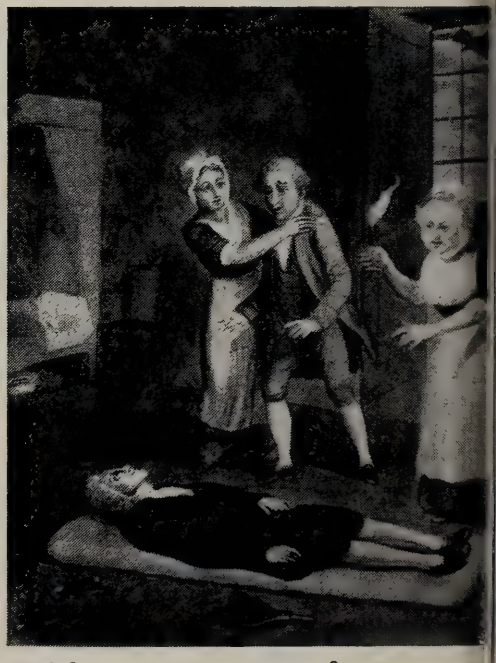
"My life is in the hands of any rascal who chooses to annoy and tease me."[1] So said the great British surgeon and anatomist, John Hunter, realizing that he could not control the anger which precipitated frequent and severe attacks of angina pectoris. According to Mettler: "His statement was no exaggeration. On October 16, 1793, he attended a meeting of the St. George's hospital staff, and, while defending the interests of several students, he was contradicted and thoroughly antagonized. The pains of angina commenced, he started toward another room, gained it, and fell dying into the arms of a physician."[2]

Why Edward Jenner withheld his paper on angina In 1777, at an earlier stage of the condition, Hunter's angina alarmed a favorite pupil, Edward Jenner, who wrote to Dr. Heberden that he feared his teacher was "affected with symptoms of the Angina Pectoris."[3] So concerned was Jenner about his former teacher's emotion-related condition that he deliberately cancelled publication of a paper on angina pectoris, fearing that Hunter would read it, and have "his fears excited by its truly formidable nature."[4]

Severity of angina described Hunter's brother-in-law, Dr. Everard Home, who witnessed his death and performed an autopsy, gave this account of the later stages of the condition:

"...the pain became excruciating at the apex of the heart; the throat was so sore as not to allow of an attempt to swallow anything and the left arm could not bear to be touched....

"The affections above described were, in the beginning, readily brought on by exercise... but they at last seized him when lying in bed, and in his sleep...."[5]



18th century ancestor of the modern coronary candidate Surgeon, anatomist, pathologist, physiologist, geologist, and teacher, Hunter had a passion for research which led him to disregard his practice, his health and even the

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Nutritional reinforcement for those who can't – or won't – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

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MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

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In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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In Our Opinion

Comments on Current Economic, Social And Professional Matters

THE IMPACT OF A PATRIARCH ON AMERICAN MEDICINE

"The Impact of Herbert Morris Platter, M. D., on American Medicine." That is the title of a citation issued in 1964 by the Executive Committee of the Federation of State Medical Boards of the United States. In part, the citation reads:

"He possesses the rare ability of always rendering service in all of his many activities. He is well known for his unyielding faith in his fellow man and a firm belief in American Medicine and is one of the nation's outstanding physicians of all times. . . .

"The Executive Committee of the Federation of State Medical Boards of the United States, as well as many others, hold Doctor Platter in highest esteem, respect him for his distinguished professional attainments, admire him for his competence, his integrity, his sterling honesty and his innate modesty; love him for those other essential qualities of heart and mind basic in the character of the true gentleman."

This national salute is only one of numerous honors bestowed upon a man who literally dedicated his life to furthering the public health by demanding the highest standards of medical practice. Before the turn of the century, he was fighting smallpox and typhoid fever as a physician and public health officer. Prior to World War I, he was laying the foundation for health codes for the public schools and for the state as a whole. For years he passed on his store of wisdom to medical students at Ohio State University.

But the crowning peak of his impact on medicine in Ohio and beyond was in his 48 years as the keystone of the State Medical Board of Ohio.

His exacting demands of those who sought to practice the healing arts in Ohio was proverbial. His knack of sifting out the unqualified was based on long, objective study. His talent for cutting through red tape to weed out the incompetent was unique.

Perhaps not as well known, but nevertheless tremendous, was this humanitarian's contribution to medical organizations.

In early November, physicians joined their fellow citizens of Ohio and of the Nation to pay homage to Dr. Platter at his last rites. From one point of view, this event marked the end of an era. But in a broader sense, Dr. Platter lived to usher in a new era in medicine.

He was a thorough believer in the principle that physicians are Number One in the guardianship of the public's health. The practice of medicine has changed. The horse-and-buggy doctor is a thing of the past; the little black bag has taken on more sophisticated airs; the kitchen table has given way to the operating room. The artist's concept of The Doctor in the new era of medicine will be different, but it will still picture the doctor beside the bedside of his patient. That phase of medicine will not change. The doctors of Ohio will see to it. The impact of Dr. Platter on medicine will continue long after his passing.

HEALTH AND SAFETY TIPS INCLUDE HOME FIRE DRILL

With the warning that more than 2,000 children die every year in home fires, an article in *Today's Health* recommends that parents set up their own fire drills. Fire drills in schools are a must, the article points out, yet the chances are 200 times greater that a child will be trapped in a fire at home.

This article is typical of the common sense information and advice that goes to readers each month through *Today's Health,* the American Medical Association magazine for lay people. This is only one example of how the AMA is helping to protect the public's health, and in our opinion, a good incentive for very physician to support the AMA.

Dr. Rex H. Wilson, medical director of the B. F. Goodrich Company, Akron, discussed preventive medicine programs as they related to occupational medicine, at a seminar in Ojai, California, sponsored by the Chemical Industry Council of Southern California.

OSMJ Scientific Section

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Dreamwork 1966

A Symposium*

An Overview of Current Research Into Sleep and Dreams

Roy M. Whitman, M. D.

In the early 1950's Aserinsky and Kleitman[1] made the initial observations that rapid eye movements are coexistent with the process of dreaming. This has resulted in an enormous amount of research[7] into the psychophysiology of this rapid eye movement (REM) stage of sleep.[19,20] Apparently this stage of sleep is sufficiently distinctive to be called "a third state of existence."

In addition to calling it the REM, or third state, other phrases characterizing this phase of sleep are: D-state, emergent stage-1, stage 1-REM, activated sleep, rapid sleep, light sleep, deep sleep, rhombencephalic sleep, and the paradoxical phase of sleep.[14] This descriptive array contains the essentials of this phase of sleep. It is characterized by rapid eye movements and the occurrence of dreaming as the subject goes from deep sleep to light sleep (hence "emergent"). There is diffuse activation of the small musculature of the body, accompanied by fast rhythm on the electroencephalograph (EEG), and the neurophysiologic locus of this phase of sleep is in the rhombencephalon.[15] Some of the inconsistencies in this phase are due to the fact that the person is in a "light" phase of sleep according to EEG criteria but he is relatively impervious to external waking stimuli, a strikingly paradoxical combination.

Every mammal thus far studied has these characteristic rapid eye movements including the cat, rat, opossum, mouse, monkey, chimpanzee, pig, sheep and goat.[20] It thus appears that the neurophysiologic substrate is present in higher forms of the animal kingdom and provides the mechanism upon which the psychologic process of dreaming is grafted. This mechanism appears in newborn infants as a major percentage of sleeping time and dream percentage time gradually decreases to 20 to 25 per cent of the night's sleep in the adult human. If we sleep one third of our lives and dream one quarter of that, then one twelfth of our lives is spent dreaming. In a normal life span this comes to six years of dreaming, making it a significant part of life from a time viewpoint alone.

In a number of experiments, investigators have established that dreams are not instantaneous and that if the subject is pushed may report that probably 80 per cent are in color.[16] In addition, the eye movements are consistent with the action observed.[3] Physiologic accompaniments consist of increased but irregular respiration, blood pressure and pulse. Finger pulse volume is decreased. There is a suppression of the skin response and, of course, an increased arousal threshold. In addition, though previously reported as an incidental observation,[18] Fisher has established the existence of partial or full erections as accompanying this phase of sleep.[8]

The impetus of this discovery has sparked more precise neurophysiologic investigations localizing the source of REM and the source of inhibition of major motor movements. Jouvet[14] has implicated the nucleus locus caeruleus as inhibiting skeletal-motor outflow, thus protecting the dreamer from actually acting out his dream. Further, he has identified the cortical

*The four papers in this Symposium were presented before the joint meeting of the Ohio Psychiatric Association and Ohio Psychologic Association, February 16, 1966, Cincinnati, Ohio.

pontile nucleus of the pontile reticular formation as being essential for the occurrence of REMs. Cats with this nucleus destroyed have no more REMs, die in toxic coma, and seem to hallucinate before death.

Other significant neurophysiologic research has been done by Evarts[4] by an ingenious micro-electrode technique. He has established the fact that firing of these individual motor neurons is as high a level or higher than in the waking state[5] during the REM phase of sleep. In addition, there is a high degree of spontaneous activity in the neurons of the visual pathways and visual cortex. Only the small neurons in the cerebrum seem to become quiescent.[6]

Dream Deprivation

Dement, one of the early and most vigorous investigators of dreaming and sleep, has become particularly interested in the phenomenon of "dream deprivation."[22] His most recent and striking findings have unearthed the rather impressive observation that during recovery REM time is proportional to the amount of deprivation. Thus, 25 per cent REM deprivation for 20 days is "made up" in ensuing nights just as much as 100 per cent deprivation for five days. Dement feels, therefore, that this is a built-in phenomenon in which there is an accumulation of a metabolite, and other investigators have speculated as to whether this is serotonin or gamma-amino butyric acid.

The phenomenon of dream deprivation for from 2 to 15 days consecutively has led to the observation in some subjects of increased appetite, an increase in anxiety and irritability, a decrease in concentration ability, and an increase in impulsivity. Three subjects deprived for two weeks consistently showed changes in the Rorschach in the direction of increased movement and creativity.[13]

Cats that are dream deprived frequently show hyperphagia and hypersexuality.[7] The decrease in REM seems to lead to a general hyperexcitability and a potentiation toward drive-oriented behavior. Psychophysiologically, it would seem that there is a cluster of functions in the limbic midbrain centers that are involved in sexual, oral and aggressive behavior.[7] From a completely different point of view there has been a great deal of psychoanalytic theory-making concerning the orality of dreaming.

Lewin's hypotheses of the dream screen, the Isakower phenomenon, as well as Spitz's work on the oral cavity,[21] all point to the initial libidinal period of orality as basic and combining with the psychophysiology of dreaming.[23] Despite Fisher's fascinating observations of the accompaniment of erections with REMs,[8] these seem to be non-genital and rather diffuse libidinal phenomena.[18] They seem very similar to Freud's recounting the observation in "Three Contributions to the Theory of Sexuality"[11] concerning the concurrence of erection and thumb sucking.

The question repeatedly arises as to the function of REM sleep. It is clearly not a restitutive phenomenon since Evarts[5] has shown that activity during REM sleep of individual neurons continues at levels equal to waking life. The sleep protecting function of dreaming must be modified to say that this paradoxical phase may protect awakening during REM sleep but definitely not during non-REM sleep. Dreams are not brought about by awakening the person during NREM sleep unless the dream cycle is about to begin anyway.

REM vs. NREM Sleep

The difference between REM and NREM sleep[17] is highly significant for the theory of sleep and dreams. In NREM sleep when mentation is recovered,[9] it usually consists of reports of abstract thoughts and uninvolved visual imagery. These thoughts are closer to waking life, often even replicas of waking life, and less bizarre and, for want of a better word, less "dreamlike."

Apparently there is an ongoing stream of mentation throughout the night which at approximately 90-minute intervals is aroused to hallucinatory intensity by the firing of centers in the pons which produces the characteristic dreams usually examined during psychoanalysis and psychotherapy. These REM dreams utilize the classic mechanism of displacement, substitution, condensation, symbolization and secondary elaboration. The unraveling of these dreams produces the most fruitful material for a psychologic investigation of the personality[22] since not only are the libidinal drives unearthed but also the ego's characteristic mode and style of dealing with these drives. An interesting theoretic possibility is that NREM dreams as reported by Rechtschaffen, et al[17] and Foulkes[9] do not utilize these mechanisms and therefore do not have a latent content in the classic psychoanalytic sense that Freud formulated.[10]

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Physical Concomitants of Dreaming And the Effect of Stimulation On Dreams

Bill J. Baldridge, B. A.

Historically there have been two conflicting thoughts concerning dreams and their influence on or by the physical forces which may prevail during dreaming. Dreaming has been viewed both as an attempted continuation of the previous waking activity and as a purely psychologic phenomena with little relation to the physical world of the dreamer. Support for either of these points of view has been readily producible. One could cite the dramatic incorporation of physical events in dreams, on the one hand, and the obvious insensitivity of the sleeper to stimulation on the other. Instances of sleep talking, sleep walking, enuresis and other nocturnal activity tended to be seen as activated dreaming while the near motionless state which accompanied most dreams added to the confusion.

Still another facet of dreaming proved difficult to resolve. This was the belief by some that dreams occurred instantaneously. The possibility that events of minutes, hours, or days might be compressed into a fraction of a second was an intriguing one and found support in both popular opinion and among scientific observers. A classic example is the "Guillotine" dream of Maury reported by Freud in *The Interpretation of Dreams*.[11] Such an instantaneous occurrence of dreams would hardly permit corresponing changes in one's physiological state, nor produce, or be affected by physical forces except perhaps in the role of a triggering mechanism.

The discovery by Aserinsky and Kleitman, of an objective method for determining when dreaming occurs, provided the tool for a systematic investigation of the many questions related to these concepts.[1] Information subsequently gathered by Aserinsky and Kleitman, and Dement and Kleitman did much to establish a firm basis from which to pursue these studies.[2-8] I would now like to present some of the findings which have been made at the University of Cincinnati using the method of Aserinsky and Kleitman and to indicate their relevance for understanding the dream process and its relation to physical and physiologic forces where possible.

Dreaming: Occurrence or Development

In one of the early studies of dreaming, Dement and Kleitman obtained dream reports from 80 per cent of the awakenings made during periods of rapid conjugate eye movements. Less than 10 per cent of the awakenings from the non-rapid eye movement periods produced a dream report with little or no recall reported when the awakenings followed the rapid eye movements by more than eight minutes.[7] This suggested that dreaming did not occur outside the rapid eye movement periods and that when dreaming was reported outside of these periods it represented some fragmentary memory of the preceding dream. More recently others, notably, Foulkes, Rechtschaffen, Goodenough and Kamiya have obtained a substantially higher per cent of dream reports from the non-rapid eye movement periods.[10,12,14,16]

We have completed a study, at the University of Cincinnati, in which a number of variables affecting dream reports were investigated by awakening subjects on a predetermined random time schedule.[6] The subject's report was then referred to the recorded eye movement activity in order to relate these two on a continuous time basis.

*APSS is the abbreviation for the Association for the Psychophysiological Study of Sleep.

The Participants

● **Dr. Whitman, Cincinnati, is Associate Professor of Psychiatry, Department of Psychiatry, The University of Cincinnati College of Medicine.**

● **Mr. Baldridge, Cincinnati, is Instructor in Psychology, Department of Psychiatry, The University of Cincinnati College of Medicine, and Consulting Psychologist, Veterans Administration Hospital, Cincinnati, Ohio.**

● **Dr. Ornstein, Cincinnati, is Assistant Professor of Psychiatry, Department of Psychiatry, The University of Cincinnati College of Medicine.**

● **Dr. Kramer, Cincinnati, is Assistant Professor of Psychiatry, The University of Cincinnati College of Medicine, and Assistant Chief, Psychiatric Service, Veterans Administration Hospital, Cincinnati, Ohio.**

In this study the per cent of dream reports obtained, as a function of the length of the eye movement period which preceded the awakening, rose from 10 per cent with activity of less than one minute to approximately 80 per cent after three to seven minutes of eye movement activity. The probability of obtaining a dream report remained near 60 to 70 per cent for all longer periods of eye movement activity. The average number of words per dream tended to increase with increased duration of eye movements.

Since the awakenings were random, many awakenings were made outside the eye movement periods. The effect was a sharp drop in dream recall for those awakenings which were made within a few minutes after the eye movements ceased. A minimum of dream reporting was obtained after an interval of 7 to 15 minutes without eye movements. This was followed, however, by a gradual increase in the frequency of dreams reported until nearly 80 per cent was again reached, after 31 to 63 minutes of non-rapid eye movement sleep. This interval corresponds approximately to the well established dream cycle time and suggests a developmental aspect of dreaming with an increasing probability of occurrence.

Activity and Dreams

For the most part, eye movements have been recorded by means of the electrical retinal potential using standard electroencephalograph (EEG) instrumentation.[1,2,7,8] Several difficulties have been encountered with this method, including interference by EEG activity and the bulk and expense of the instrument. A method of mechanically recording the movements of the eyes by means of a strain gauge was developed in our laboratory which circumvents some of these difficulties.[3] With the strain gauge method, smaller eye movements may be detected without interference from the electrical activity of the brain. The use of this method of recording eye movements, which does not depend on the electrical potential from the retina, made possible the recent demonstration, by Gross, of rapid eye movements during dreaming in the congenitally blind.[13] Previous studies of dreaming in the congenitally blind had produced little or no rapid eye movements indicating their occurrence during dreaming to be a learned phenomenon.

Initially Aserinsky and Kleitman reported that dreaming with eye movements occurred during periods when other muscle movements were at an extremely low level or nonexistent.[1] Dement and Kleitman, however, speculated that other fine muscle movements should in fact occur.[8] Our own observations led us to believe that such fine muscle movements, not only should but did occur along with the movement of the eyes. A subsequent study demonstrated that these observations were correct.[4] In this study, ten subjects slept undisturbed overnight while recordings of movements were made by means of strain gauges attached to their eyelid, throat, wrist and ankle. From these records it was seen that when eye movements began, all channels became active and when the eye movement activity ceased, activity from the other channels also ceased. Correlations between eye movement activity and the average of the activity from the other three channels were greater than .75 for 7 of the 10 subjects in the study.

Influencing Dream Content

An early study by Dement and Wolpert reported only moderate success in their attempt to affect dream content by means of external stimulation.[9] Of the three stimulus modes used by these investigators, only a spray of water on the skin of the subject was reported to be effective in producing a change in the dream. We have undertaken a series of studies to systematically investigate the effect of a variety of external physical stimuli on dream content.[5] The first to be completed was one to determine the effect of movement induced by raising and lowering the upper part of a hospital type bed. Results indicate those dreams which occurred with movement can be distinguished from those obtained from control awakenings without movement. In addition to a number of specific movement activities in these dreams, such as falling, flying or riding a motor-scooter, dreams from the awakenings following movement are generally distinguishable on the basis of increased activity on the part of the dreamer.

Other forms of stimulation being studied include temperate changes produced by flowing water of different temperature through rubber tubing imbedded in a pad on which the subject is sleeping. Here, stimulation with cold may result in a reference to getting food from a refrigerator, while stimulation with a warm temperature may result in reference to a warm day.

The effects of internal physiologic states are also being studied by depriving the subjects of food for a period of 24 hours. The dreams obtained are then compared to the dreams reported by a subject under normal conditions. The effect produced with some seems to be an obsessive reference to food in their dreams while others are more likely to respond with anger. A sufficient amount of data has not yet been collected from which to draw any firm conclusion.

Investigation of Dream Process And Related Mechanisms

It seems reasonably certain now that many forms of physical stimulation and internal physiologic states may produce changes in the contents of the reported dream. A great many more studies will need to be completed before we will be able to specify the exact nature of these effects. The use of different forms of stimulation and of different manners of presentation should be employed to answer questions, such as the

effects which may be produced by a stimulus which begins prior to the onset of a dream and one which is initiated after the dream has started. The repeated use of the same stimuli during different periods of the night may provide information concerning the variety of symbolization and the various techniques of defense employed by the dreamer. It should also provide some measure of the qualitative differences which appear in dreams as a result of the purely physical and physiologic forces which are known to be present.

The variety of muscle activity during dreaming is now known to be extensive. Some more general understanding of its significance is beginning to take place. Kuntz has emphasized the importance of the developing musculature in the course of the phylogenetic development of the central nervous system.[15] With this view in mind, a closer analysis of movement during dreaming may indicate something of the organization of the neural mechanisms involved.

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Dreams and Conflicts

Paul H. Ornstein, M. D.

This brief report describes an experimental design in which *structural conflicts* are hypnotically implanted in volunteer subjects and then the derivatives of these conflicts are *traced* in the free-associative interview material, the hypnotically induced dreams and in the dreams of the night.

The combined use of hypnotically implanted conflicts and the modified Kleitman technique for the collection of dreams is eminently suited for studying the impact of these implanted conflicts upon dreams, feelings and verbal behavior.

Method

In this study undergraduate students of the University of Cincinnati served as experimental subjects. They were recruited by the U. C. Employment Bureau and were paid for their participation. The screening of those sent to us was done by a brief clinical interview, a questionnaire and the use of two Thermatic Apperception Test cards to determine hypnotizability.

After one or two training sessions, each lasting for about one hour to achieve quick induction and posthypnotic amnesia, a date was set for an experiment.

On the experimental day, at 9:15 A. M., the subject is hypnotized. Once he is in deep hypnosis and ready for the implantation of a "structural conflict," the experimenter selects the conflict randomly from 15 cards. Each of these cards contains the typewritten text of one of the 15 conflicts used in these experiments. (See Table 1.)

TABLE 1. *"Structural Conflicts" for Hypnotic Implantation*

DISTURBING MOTIVES	versus	REACTIVE MOTIVES
1. *Hostile wishes*		a. Fear of physical injury
		b. Fear of loss of love
		c. Fear of feeling ashamed
		d. Fear of feeling guilty
		e. Fear of losing control
2. *Sexual wishes*		a. Fear of physical injury
		b. Fear of loss of love
		c. Fear of feeling ashamed
		d. Fear of feeling guilty
		e. Fear of losing control
3. *Dependent wishes*		a. Fear of physical injury
		b. Fear of loss of love
		c. Fear of feeling ashamed
		d. Fear of feeling guilty
		e. Fear of losing control

After the conflict is implanted, the subject is told that his intense conflict will create a dream. Instruction is given that after the dream ends, while still under hypnosis, the subject is to tell his dream. Subsequently, amnesia is suggested for the entire experience — with a random variation that the hypnotic dream is at times allowed to be remembered after awakening.

The implantation procedure usually takes 30 to 45 minutes. At 10:00 A. M., the subject is aroused, tested for amnesia and sent to another office where he is interviewed by a psychiatrist, mostly in the presence of another observing psychiatrist, for about 20 to 30 minutes, with the technique of associative anamnesis.

At the beginning of this interview, the subject is again tested for posthypnotic amnesia. The interviewer also asks for early memories. The entire procedure is tape-recorded and subsequently transcribed.

That evening the subject sleeps in the Dream Laboratory of the Department of Psychiatry at the Cincinnati General Hospital, and his dreams are collected by a modification of the Kleitman technique. These dreams are recorded and transcribed along with associations to the dreams which are asked for when the subject is awakened.

The Use of Our Data

The data are then used as follows: the interviewer and observer independently make an immediate formulation after the interview as to the most likely conflict of the 15 possibilities. They also give a second and third choice, and record these.

Subsequently, members of the entire team receive a transcript of the interview (with or without the hypnotic dream, depending on whether it is recalled or not) and of the night dreams. The transcript of the implantation is withheld. Then in a joint session the team works with the interview, the hypnotic dream when available, and the night dreams. They use all of this material to arrive at separate formulations of the focal conflict.

Once the formulations are recorded, the implanted conflict is revealed and the data are reexamined in the light of this new information. The interview and the dream material are then combed carefully for evidence which *supports* or *refutes* the hypothesis that there has been a "take" of the implanted conflict.

Another, recently introduced, method of working this material over is the independent, clinical-intuitive interpretation of the data by two members of our team in a stepwise fashion.

1. A formulation of the focal conflict based on the interview alone;
2. A similar formulation based on the early memory alone;
3. A formulation on the basis of the hypnotic dream, if available;
4. A formulation based on the night dreams;
5. A formulation based on *integrating* all of the available information.

Two other members of the team work on the same material, in the same sequence, using a scoring technique, rather than the clinical approach.

Areas of Study

It is immediately evident that this method provides an opportunity for experimental studies in many important areas of clinical practice:

- 1. The consensus regarding the validity of psychodynamic formulations;
- 2. Steps in the process of clinical inference;
- 3. Teaching focal conflict formulation in a fashion similar to the clinicopathological conference in medicine;
- 4. A comparative study of hypnotic dreams and night dreams;
- 5. The influence of implanted conflicts on early memories; and finally,
- 6. The interrelationship of the artificially induced conflicts with the subject's own naturally occurring conflicts.

You may rightly argue at this point that before we can state with certainty that our method and our data are really suitable for the studies I just enumerated, we have to be able to demonstrate that the conflicts we implant *actually become implanted* and visibly affect the subject's behavior, verbalizations, hypnotic and night dreams.

I cannot hope to be convincing in such a brief report, but perhaps you may get a glimpse at what is involved if you follow me in a bit of clinical exercise:

I will give you a highly condensed version of an interview with one of our subjects, a hypnotic dream and one of her three night dreams. I invite you to think along with me and attempt to guess which of the three major disturbing motives and which of the five reactive motives were implanted in this particular experimental situation.

The three disturbing motives we use in our experiments are: (1) Hostile Wishes; (2) Sexual Wishes; (3) Dependent Wishes. These may each provoke one of five reactive motives: (a) Fear of Physical Injury; (b) Fear of Loss of Love; (c) Fear of Feeling Ashamed; (d) Fear of Feeling Guilty; (e) Fear of Losing Control. We therefore have 15 possibilities to choose from. However, if you succeed in choosing the correct disturbing motive, one of only three, you will have done very well with this sample.

A Sample of Our Data

The subject was an 18 year old girl, student at U. C., who said essentially the following in a free associative interview:

She wanted to be a nurse when her little sister was born until she was a high school senior. From then on she no longer wanted to be a white slave. She runs the family, her father is dead, because mother is not as good at it and she is the first one to arrive home every day — mother and older sister work and younger sister is in school. The summer after she graduated from high school she asked mother to let her run the house completely. She did the shopping, planned the meals, spent the money.

Then she recalled a dream she had under hypnosis:

I pictured myself doing laundry by hand, like sort of with the long skirts like a pioneer — but it wasn't quite pioneers — there was an electric bulb in the background, the bare wire type, like poverty — when you are struggling.

In her associations she seemed to present a Cinderella picture of herself at first. When the interviewer asked her about it, she denied being or feeling like a Cinderella and said that no one tells her what to do; she volunteers. The picture in the dream reminded her of a Salvation Army girl who is out with the drums trying to save people.

The interviewer wanted to know if the Salvation Army image meant to her that she was straight-laced.

She responded by saying that she was reserved and shy, but went on to talk about her boy friend, who was very aggressive and whom she admired in spite of seeing some of his faults.

One of her night dreams in the Dream Laboratory was as follows:

I was going to tell one of my roommates about sleeping here and the advantages of this. Then there was an article in the paper about some high school students who just spent two and a half months living in a lavish apartment and taking care of themselves . . .

The Interpretation of Our Sample

Unless some of you want to reveal your guesses, I will go on to tell you what the research group thought of this material. At this point Dr. B. Clemente of the audience suggested that the implanted conflict was: "Dependency vs. Fear of Loss of Love."

Three out of four in our research group chose "Dependency Wishes versus Fear of Loss of Love." The conflict that was actually implanted was "Dependency Wishes versus Fear of Feeling Ashamed." It is to be acknowledged that the differentiation of these two *reactive motives* is extremely difficult.

In tracing this conflict in the material, I can only mention a few of the obvious ones:

In the *interview,* the first thing she revealed was that she wanted to be a nurse: A frequent solution for dependency conflicts. The rest of the interview shows the solution to the conflicts: excessive need to be independent (which in this instance was a suggested solution).

In the *hypnotic dream* the assertion of independence suggests a reaction against underlying dependence. Shame seems to appear in the form of the long dress that covers up what should not be seen; then the revealing electric light bulb also suggests exposure in contrast to what is implied by the Salvation Army girl association.

In the *night dream* the dependency wish comes through in the idea of being given to (she was paid for sleeping here). The shame is handled by spreading it around to a number of people and the implication of her working for the care she receives.

This condensed sample may sufficiently illustrate the kind of symbolization, disguise, displacement which is utilized by our experimental subjects to elaborate the implanted conflicts and express them, unbeknown to themselves consciously in the interview and dreams.

How do we know that we are dealing with the implanted and not with the natural conflicts of our subjects? The answer to that is relatively simple. We implant a number of different conflicts in the same subject and often the same conflict more than once. This provides us with an opportunity to study the differences in the material as they relate to the different conflicts implanted.

Because of these discernible differences, this type of material is well-suited for teaching purposes. It is possible for those engaged in this diagnostic "game" to retrace their steps in the inferential process once the implanted conflicts are revealed and to recognize where they were led astray in their formulation.

The implanted conflict serves as radioactive substances do in medicine and surgery, and the clinician's empathoscilloscope has to be sensitive enough to pick up the different, disguised and symbolic transformations.

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Drugs, Depression, and Dream Sequences

An Exploration of Dream Content Changes Induced by Medication, by Psychopathologic Conditions, and by Variations in the Ego's Adaptability.

Milton Kramer, M. D.

The primary focus of our dream research group here at the University of Cincinnati has been on the study of the *content of dreams* rather than on the *physiologic process of dreaming.* Certainly our therapeutic orientation has considerably influenced and guided our work in this direction. As poetry will never be completely understood in electrophysical terms, dreams cannot be explained solely from a description of eye movements and activated Stage I electroencephalograms. Even granting the physiologic and biologic primacy of rapid eye movement (REM) sleep, we are still left with the problem of the function of the concomitant psychic activity of dreaming, which cannot simply be reduced to the underlying somatic and physiochemical processes. What Kety said about memory, that we may sometimes have a biochemistry of memory but never of memor*ies,* holds true for dreaming and dreams[9] as well.

Our initial interest was to use the dream, now that the vagaries of dream recall could be substantially bypassed, to examine the psychologic shifts which accompany the taking of tranquilizing drugs. As clinicians, we view the dream as representing the most significant, condensed, psychologic product of the organism.[27] The dream is every man's personal projective occurring three to five times a night, every night. That tranquilizers were known to affect the hallucinations of the dream[3, 6, 18, 23, 25] and of psychosis and that the site of action of the drugs and the center for dream initiation were both subcortical[15] intrigued us all the more.

Drug Studies

Our intent was to *psychoassay* the newer drugs by examining their effects on dream content. To this end we have undertaken studies of the influence on dream content of various types of psychoactive drugs. The drugs we have studied are Compazine®, a major

tranquilizer; imipramine, an antidepressant; meprobamate, a minor tranquilizer, and phenobarbital, a sedative.[29,30]

Our approach has been to obtain baseline nights of dreaming, then to start the subject on medication, and finally to obtain additional dreams from the subject after he has been on the medication for at least several days. The subjects sleep in our laboratory at either the General Hospital or the V. A. Hospital in Cincinnati. Dreaming is determined by eye-movement indicators.[4] Subjects are awakened to report dreams after five minutes of dreaming to keep the dream reports somewhat comparable.[14] We have the subject report his dream into a tape recorder from which typed scripts are prepared. These typed dream reports are then rated along seven dimensions using rating scales we have devised.[30] The dimensions along which the dreams are rated include hostility, dependency, heterosexuality, homosexuality, anxiety, intimacy, and motility.

The psychoassay of tranquilizing drugs has yielded a number of interesting results. Our most striking finding is the tendency of imipramine to stimulate the expression of hostility in dreams.[30] We speculated that this increase of hostility discharge in dreams could result in a reduction of aggressive instinctual pressure. If this were the case, then the discharge of hostility in the fantasy of the dream might be linked to the antidepressant effects of imipramine, the idea being that the blocked self-directed aggression so common in the depressed was finding some release in the hostility expressed in dreams. Our work on enuresis, in which enuretic episodes were found to substitute for dream periods, supports this notion of the dream having a discharge function.[22]

The major specific effect on dream content that we found for meprobamate could also be seen as an example of the discharge function of the dream. Scores on the motility scale were found to be significantly elevated over the baseline in a subject taking meprobamate. We conceptualized this change as perhaps reflecting a compensatory discharge of motility in the dream resulting from the alledged muscle relaxant properties of meprobamate blocking motoric discharge via peripheral motor channels.[29]

Both imipramine and meprobamate led to a decrease in the number of dreams reported per night. This may relate to the suppression of REM time described for most tranquilizing medication.[8,10,11]

Phenobarbital and Compazine tended to cause elevated scores on the sexual scales, the former on the homosexual scale and the latter on the heterosexual scale.[30] These rises were trends which did not reach statistical significance. However, we wondered if phenobarbital might have fostered a passive state because of its relaxant qualities which was reflected in expressions of homosexuality in the dream. This does not fit our thesis of the discharge quality of the dream which we have described above. The tendency for Compazine to elevate heterosexual scores remains unexplained.

We noted a series of changes in several of the other scales which occurred with all of the drugs that were studied.[29,30] These changes were probably related less to the pharmacologic effect of the medication and more to the experimental setting and the doctor-patient type relationship engendered by the giving of drugs. The changes we observed with all of the drugs were a rise in scores on the anxiety and dependency scales and a decrease on the intimacy scale. The experimental setting tends to be anxiety provoking and stimulates many concerns which are inevitably reflected in the dreams of the subjects.[31] The distancing implied by a decrease in intimacy scores could well be seen as the defensive maneuver of an anxious patient. That being given a pill would foster an increase in dependency is to be expected as it often raises hopes of further care from the giver. The introduction of medication into the doctor-patient relationship could tend to decrease the intimacy of the relationship.

We feel encouraged that by utilizing the dream, the most central intrapsychic product of the organism, we can, by quantifying the psychologic forces in the dream along traditional psychologic vectors, begin to evaluate the psychologic effects of the tranquilizing drugs in a meaningful way.

Depression Study

Our interest in the dreams of various diagnostic entities such as schizophrenia, traumatic neuroses, and depression lead us, in view of our having found such a striking effect of imipramine on the dreams of normal subjects, to study first the dreams of the depressed.[17] We obtained two nights of dreaming from ten depressed patients while they were on an imipramine placebo. They were then switched to the active medication and had their dreams collected one night a week for three additional weeks. At the end of the fourth week when the last dreams were collected, all of the patients had improved.

Our purpose in studying the effects of imipramine on the dreams of the depressed was in searching for possible shifts in various kinds of dream content as well as to observe any change in dream frequency or dream recall. We were also interested, as part of our curiosity about the dream characteristics of various diagnostic entities, in noting whether the dreams of the depressed were different from those of the non-depressed.

What we found was that the depressed recalled dreams less often than the non-depressed, 51 per cent recall as compared to 85 per cent; but that the frequency of dream episodes per night was essentially the same, 3.7 as compared to 3.4.

We noted that the depressive themes described by Beck[5] as characterizing the verbalizations of depressed patients at times of depression, namely: low self-regard, deprivation, self-criticism and self-blame,

overwhelming problems and duties, self-commands and injunctions, and escape and suicide did indeed occur more frequently in the dreams of the depressed than the non-depressed. Interestingly, 49 per cent of the depressive themes in the dreams of the depressed were themes of escape while only 12 per cent of the depressive themes in the non-depressed were in this category. No single theme predominated in the non-depressed as escape themes did in the depressed.

When the dreams of the depressed were examined for reflections of feelings of helplessness or hopelessness as defined by Engle[7] and Schmale,[24] the dreams of the depressed were found to contain such feelings in 33 per cent of cases while such themes were present in only 7 per cent of the dreams of the non-depressed.

We were unable to demonstrate any shift in the frequency of dream recall or in any of the dream theme parameters concurrent with clinical improvement in the depressed patients when we compared the first night of observation to the last. We have not as yet examined these dreams to explore for possible shifts in hostility expression concomitant with clinical improvement.

A number of speculations about the dreams of the depressed occurred to us as result of our observations. Even recognizing the dream suppressant effect of imipramine, we felt the most likely explanation for the decrease in dream recall in depressed patients is to see this as part of the repressive defensive process exemplified in the decreased productivity of the depressed state and related to the interpersonal technique of not reporting dreams to preserve relationships[28] and to avoid the pain which, for the depressed, accompanies thinking.[2] A physiological explanation of reduced dream time appears untenable to us to account for the decreased dream recall in the depressed.

It is clear from our observations of the dreams of depressed patients, as reflected in dream recall percentages and various dream themes, that their dreams do not mirror their waking clinical state. Apparently the dream lags qualitatively behind the clinical state in indicating change. If the intrapsychic indicators do ultimately change, one might consider that the lag reflects the still precarious adaptation of the depressed patient. If this is so, decisions about recovery and readiness for discharge from the hospital should take this fact into account.

Dream Sequences

One of the points of view about dreams that I stated above was that for us the dream was the most significant, intrapsychic product of the organism and that it was truly each man's personal projective. With the availability of a larger number of dreams from a single night, we became interested in what this nightly projective might tell us about subjects and in a sequential analysis of these data, i.e., how do the various dreams of a single night interrelate.

Most pre-REM observers of the multiple dreams of a single night deal with pairs of dreams rather than dream series, by which we mean three or more dreams. These observers noted that dreams of a single night form part of a single whole,[13] that often they have a condition-consequent relationship one to the other,[12] and that they may differentially disguise object and impulse.[1]

It was a group at the University of Chicago[21,26] who first studied the multiple dreams of a single night collected by awakening the subject at night when physiologic indicators of dreaming appeared. They were able to show that all the dreams of a single night do deal with the same or a limited number of conflicts. Further they noted that the organization of a particular dream depends at least in part on the consequences of the attempted solution in the previous dream. And finally, that the dreams within a single night seemed to reflect a cycle of tension accumulation, discharge, and regression or quiescence which may be related to a psychologic sequence of alternating ascendancy of disturbing and reactive motives in the sense that Thomas French uses these concepts.

In view of the paucity of data in the clinical literature on the multiple dreams of a single night, we were curious as to the incidence of such multiple dreams in psychotherapeutic situations. We examined the case records of eight analytic cases: they contained a total of 2744 therapy hours. A dream was reported in 1584 of these hours, or 58 per cent of the time. Multiple dreams, i.e., three or more dreams from a single night, were reported in 201 hours, or in 13 per cent of those hours which contained a dream — or in 7 per cent of all the therapy hours examined.[16] Multiple dreams of a single night in therapy are a relatively rare occurrence and this might account for the paucity of discussions of such situations in the clinical literature.

We continued our inquiry into the interrelationship of the multiple dreams of a single night[16] by examining the dream sequences of two subjects, who had been part of another study.[28] We were able to discern from their experimentally collected dreams, as well as from clinical data, the previously described sequential pattern in which progression occurs and in which each dream acts as a "night residue" for the next dream. This pattern accounted for about 50 per cent of our experimental data.

I would like to illustrate this sequential pattern by the following series of dreams from a female subject:

FEMALE SUBJECT — *Dream Night No. 6*

(6-1): "This little girl was asleep. She was being real cute, prolonging things for money or to stay in the hospital longer."

(6-2): "I passed Frank's wife in a car. She saw me come . . . she pulled away. I got kind of mad. I decided it didn't make any difference . . ."

(6-3): "I was playing tennis. I hit it back real hard. We won the game."

(6-4): "A patient didn't need the doctor after all. She

started out thinking she needed a doctor but she didn't. She had a big bandage on her stomach."

(6-5): "Doctor was not able to treat patient because he was not properly licensed. Patient is planning to use surgery against the doctor."

The sequential pattern in this series expressed a dependent sexual longing toward the experimenter/doctor which led to a feared but expected rejection by the wife/mother in the second dream. The conflict was mastered in the third dream by an aggressive victory with her own partner. The fourth dream revealed a rejection of the previously felt need though evidence remains that the need still exists. In the last dream, a more intense rejection in the form of an attack on the doctor serves to deny any need.

We found another pattern of dream interrelationship in examining our data which had not been previously described. This was repetitive in type rather than sequential. This repetitive pattern accounted for about 32 per cent of our experimental data. In contrast to the flexibility of the sequential pattern, this pattern suggests a traumatic-like state in which the conflict is re-stated with little progression or mastery occurring.

Let me illustrate this repetitive pattern, again from the dreams of our female subject.

(3-1): "Somebody was lost. It was a dog and they were trying to find out where it lived. A little kid or somebody couldn't tell where he lived. It wasn't my dog, though. I wasn't lost. This person who was lost was always fumbling around leading everybody else around because he didn't know what he was doing. Some boy, I think. Somehow we had telephone numbers, trying to find the right one. It was supposed to be that little boy that was lost."

(3-2): "They filled up the car. There wasn't enough room, unless I went back with the people we went back with before. I could go back with someone else. The place we were going was an orphanage someplace, some house, a place like that."

(3-3): "I was dreaming about visiting, I think it was some EEG laboratory, or something like that where the mothers could leave their children, and they could go shopping. I doubt whether they could, there wouldn't be enough room for all these people."

In all the dreams of the night, the subject dealt with her fear of being abandoned and her method of recontacting her family — calling on the phone, riding in a car, and being picked up.

We wondered if dream patterns of a sequential and repetitive type might be two ends of a continuum with one reflecting a flexible-adaptive coping state of the ego and the other an ego whose solutional capacity is currently constricted. We were able to describe one night of dreaming on which an intermediate pattern occurred. In this case, progression developed and then restatement occurred.

As I indicated at the beginning of my remarks, the primary interest in our group is in the dream more than in dreaming. We cannot accept Nelson's comment*,[19] made in 1888, which seems echoed in the flurry of studies on dream time with little or no interest in dream content, that it's not what you dream that matters but only how much. I would like to conclude with a bit of verse[20] by a graduate student that may explain our romantic commitment to the richness of dream content rather than the sterility of dream time. It goes like this:

One mystery alone remains
Of my beloved's sleep:
We've solved the movement of her eyes
And why they do repeat;
We know what brings her breath in sighs;
We've tracked her EEG;
The haunting doubt that still remains
Is does she dream of me?

What better reason could one have for an interest in dream content?

*Nelson, J.: *Amer. J. Psychol.*, 1888.

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Introduction to Widowhood

The Role of the Family Physician

GEORGE D. CLOUSE, M. D.

THE family physician is often in the unique and unenviable position of introducing a woman to widowhood. Here, as in marriage counseling, he becomes an important member of the medical team upon which almost everything else turns. His words and actions are often discussed by the family and relatives for days afterwards, and his management can guide the family through troubled times ahead.

The task is never easy. For a physician it is doubly difficult because it symbolizes his defeat in the constant struggle against death. Physicians who do not know the family well may brusquely offer some words of comfort and condolence, then hurry away quickly before their emotions show. The family doctor is expected to do more than this, and, in fact, is negligent if he does not. He may not even feel he can say the right words, but that is not as important as is his *presence.* He probably would not have to say much so long as he was *there* and *remained* there while sorrowing ones lean on him for support until their emotions come somewhat under control. This is one time when he must convey the absolute impression of not being in a hurry. The last thing a bereaved widow can tolerate is being left alone at such a time. Compassion and helpfulness are demonstrated best by being close at hand. The greatest reassurance comes from not feeling abandoned.

Trivial points? Unnecessary? Not at all, because the family practice of medicine is based on treating people as human beings! These are the little things that are so important and the stuff that lives are built upon. These are the things that make people respect and love their physicians even though they might owe them money. People might possibly be persuaded to permit the scientific part of medicine to be socialized, but they will never permit it for the human and compassionate side.

The Immediate Situation

An illustrative case history will serve to bring out how some of the problems relating to widowhood may be managed. The suggestions given here represent one approach only; and, undoubtedly every physician will have his own approach.

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The Author

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A 42 year old man on a hot July afternoon walked into his house from washing his car. He told his wife he "couldn't breathe" and collapsed on the kitchen floor. Her voice was laden with emotion when she called me. "He's awfully bad. Can you come right away?"

I told her to summon the Emergency Squad and I would be right over (in spite of an office full of patients). The squad beat me there and was administering oxygen when I arrived. A stethoscope was immediately applied to the chest, at the same time I felt for the carotid pulse. No heart activity was present, and one of the squad murmured there had been no breathing. An injection of epinephrine was given into the area of the heart. The wife was constrained in an adjoining room by a neighbor woman who had come running when she heard a cry for help. I wanted the wife nearby but not actually in the room, although she inquired every ten seconds about her husband. I asked her to call her minister to see if he could come over.

External cardiac massage was begun even with the futile realization that the patient was already dead.

The 15 year old son kept yelling, "How's my Dad?" When told to shut off a radio that was still playing, he went over and smashed it (right in the middle of a commercial). The wife asked if I could cut the chest open and massage the heart. I made no reply but stood up and shook my head slowly. The widow then became completely hysterical and the son threw himself on the floor beside his dead father and beat the floor with his fists.

I gave a hypo of morphine gr. $\frac{1}{3}$ to the widow with no protest although she was abnormally afraid of "shots." The son was given morphine gr. $\frac{1}{4}$. It is my opinion that there is no better drug for sedation in such instances because of the sense of well-being that it imparts. The relatively high dosage

in children seems to be well tolerated because of their intense emotional level.

"He's gone isn't he?" cried the wife. I nodded slowly in answer. I believed first of all, she should be told the truth. I suggested the squad continue giving oxygen for a while longer, then led her into another room and questioned her regarding her husband's recent health. She described the symptoms of angina which he had developed several days prior to death. This, plus knowledge of the man's hectic living habits and the history of his father having had a cardiac death at a similar age, made a diagnosis of coronary occlusion most likely. Nevertheless I stated that although I was reasonably certain as to the cause of death I could ask the Coroner to review all facts and make the final diagnosis. Although she didn't think this was necessary, I felt the choice should be hers so that there would be no unanswered questions later.

I then dismissed the Emergency Squad and reassured the police officer that I would sign the death certificate. I asked the neighbor to get a sheet and cover the body, but first to close the eyelids. The wife asked if pennies could be put on the eyelids and this I did. I believe it is important to go along with certain rites and procedures at this time to fulfill the family's feeling that everything was done properly.

The man's mother and the woman's father, being the only elder relatives still living, were then notified. In the meantime the woman was reminded gently that, had he been in the best hospital in New York City with the best of medical attention, his death could not have been prevented. When relatives arrived and the first gush of hysteria had subsided, the minister arrived and administered last rites. Then the family was brought together and told they must select a funeral director. A small difference of opinion was resolved by picking one the deceased himself would have chosen. Not until then did I leave the house.

Realization of Widowhood

Later that evening I made another visit to the home. The widow was given two capsules of pentobarbital, 150 mg. each, which she laid aside until I personally administered them with a glass of water. Her relatives had volunteered to stay with her, so a small number of meprobamate tablets were given to a responsible looking brother-in-law to administer to the widow during the next several strenuous days. He was warned that she must not have access to them to swallow during an overwhelming feeling of despondency.

Then I sat down and invited the widow and the family to ask any questions. Nearly always the widow has a gnawing guilt feeling and some members of the family are prone to blame the person's death on various circumstances. Such feelings are often expressed: "If only . . . he might be alive today." These feelings were thoroughly aired and described as perfectly normal reactions. The tension in the room was considerably lessened when everyone seemed satisfied that everything had been done that could be done.

It was also pointed out that it was normal to have mixed feelings, and everyone should be allowed to express any hostility or bitterness; even some irrationality.

Then the son was taken aside and told he could help his mother by giving her encouragement, by staying closer around the house and by being more confidential in talking to his mother about his own personal feelings and problems.

At this point one of the relatives was determined to make several large pots of coffee. She was advised not to prepare the coffee, because by the time of the funeral, the relatives tend to become more irritable and emotionally depleted without additional stimuli. Under such conditions remarks may be made which should not be expressed while feelings are "raw."

Instead the busy relative was asked to supervise the feeding of other members of the family and organize food contributions from neighbors. The bereaved wife was advised to eat small amounts of high energy food at frequent intervals, even if she had to force it down.

Two days later I stopped at the funeral home during visiting hours, comforting the bereaved wife that her husband had lived a useful life and that he had left a legacy of love and respect with his community, his associates, friends, and relatives. Seeing that her emotions were under control she was given a limited number of pentobarbital capsules for sleep to use "as long as you need them." This was obviously offering trust at a time when she did not especially feel trustworthy, namely, the beginning of a long and concerted effort of adjustment. Knowing the completely hopeless feeling she had and the many difficult problems ahead, I scheduled an office visit for her several days after the funeral. I told her I would like to have her make weekly visits to the office for several weeks and then at less frequent intervals as her self-confidence returned.

I reminded several members of the family to allow her to cry if she wanted to, and to be left alone if she wanted to, but not for too long a time. I obtained assurance from the brother-in-law that insurance details, financial arrangements and legal problems would be given attention.

Office Visits Helpful

The subsequent office visits became counseling periods on helping her meet the problems she faced, helping her regain her self-confidence, and helping her begin to look ahead instead of backwards. In all the discussions the word *widow* was never mentioned because it seems to be a repugnant word to those misfortunate women to whom it applies. In our discussions it was necessary to demonstrate sym-

pathy and compassion without at any time becoming sentimental or allowing over-dependency.

I urged her first to cry without restraint if she felt like it, and to spend some time alone re-living some of the pleasant memories she had shared with her husband. She said she felt that God took him because his work on earth was finished, but that He left her here for a purpose. I suggested that her husband was always near and she could speak to him in her thoughts, or even aloud if she felt like it.

Later I drew her away from thoughts of self-pity and reminded her not to indulge excessively in remorse, that there was a job to be done. It was suggested that at first she need face only a few hours at a time — not even a day. It was pointed out that one of her first duties would be the painful task of writing her "thank you" notes and she was urged not to postpone this but to get it out of the way. She was urged to seek the advice of her male relatives about financial planning which often becomes the most important concern to face. She was reminded that her decisions should be tested by applying the question of how she would feel about them ten years hence. No problem could be compared to the education and rearing of her son. Later on she would never remember little mistakes she would inevitably make, so long as she could know she had done her best as a mother.

I discussed the many financial worries with her and the tremendous responsibility that must be shouldered as she became the sole head of the household instead of a dependent wife. Again she was reminded to feel free to seek help and not try to carry her burden alone.

Feelings Often Overlooked

She seemed quite relieved to hear that other women had similar feelings about some of the unspoken things, such as: The bed not feeling "weighted-down" properly; the loud noises she heard at night that she never heard before; the letdown after the first week or two when friends and relatives had exhausted their time and sympathy and there was much time to be alone; the dreaded long week-ends of too much quiet; and the things that got lost somehow even though she could no longer blame her husband for misplacing them. She wondered to whom would she tell about that amusing thing she saw at the super market; or how in the world could she ever get someone in to fix the leaky faucet; who would be interested in hearing about her awful loneliness, inadequacy, and despair; and who would really care if she just ended it all?

She remarked about how her meal planning had been considerably altered. She discovered that she over-bought at the super market, and had lots of uneaten food with no one to praise her cooking.

She mentioned that as the same day of the week and the same day of the month of her husband's death approached, she would develop an anniversary type of anxiety. Just knowing she was not alone in these feelings seemed to give considerable consolation.

Gradually, in the course of our discussions, she began to learn that living with these feelings meant not only gritting her teeth or shrugging them off, but rather a re-focusing of her thoughts from inward to outward.

Turning Toward the Future

It was emphasized that she must think about other people and help others overcome personal anguish. She was urged to consult with her minister about how she could start to live creatively and give comfort to others who were lonely or sick. In time she made many new friends simply by being sincerely interested in them. As she became fairly active in her church and PTA activities, her self-confidence returned and she made her own decisions more courageously. She remarked that her husband was probably looking down on her quite proudly.

She said that she had been whistled at on the street, and it helped her morale tremendously because it was very important to her that she was still desirable as a woman. This was a cue for a brief comment that she was dressed attractively.

Mild sedation was prescribed sparingly, but after several months she indicated she thought she needed more. I realized that the numbness following her loss was beginning to wear off and that she was becoming more aware of her physical needs, coupled with depression. This was considerably relieved first, by prescribing Etrafon® with its antidepressant effect, later followed by Pertofrane®, both given once or twice a day.

Once again she seemed relieved as we discussed the subject and spoke openly of the problem. I agreed that prayer would help as it had always done and that hard physical work would do her good. She was told that washing walls was a good way to work off emotion, and that there was nothing like spading up a garden. Besides, helping things to grow was another creative activity. Also, she was urged to step up the pace of her social activities.

After a long interval she saw me again, and I sensed a certain vague restlessness. After talking awhile in generalities I suggested she begin to think entirely of the future and start by getting rid of her husband's old pipes. It was suggested she might even consider the possibility of re-marriage. She said she would give this some thought, although it was obvious she already had.

Summary

In summarizing the main problems to be considered in the foregoing case history, the family doctor plays

a key role in a difficult and complex human situation. The following points are worthy of re-emphasis.

1. Be present in the time of need and never act hurried.

2. Pay particular attention to religious rites and amenities.

3. Sedation: Morphine first followed by judicious use of tranquilizers or antidepressants.

4. Discuss with the family to relieve feelings of guilt and blame.

5. Have constructive discussions with the widow's children and responsible relatives.

6. Schedule a definite series of office consultations with the widow, while anticipating her feelings, building her morale, helping her to live creatively and outwardly, giving confidence and encouragement.

7. Avoid using the word *widow.*

* * *

COMMENT*: Dr. Clouse's article presents a "how to do it" discussion in an area about which we have had far too few specific instructions. He has tackled a subject that most physicians meet many times but have found little in their professional education or reading to prepare them to handle.

In treating his patient, Dr. Clouse used well accepted psychiatric techniques and, I am glad to say, did not disguise these techniques with multisyllable verbiage and esoteric language. He used supportive psychotherapy and chemotherapy early and when needed. I do not necessarily agree with the use of morphine as a sedative or tranquilizing drug, but I do believe that every physican should use those drugs he knows best and feels most comfortable in using. While continuing the supportive therapy, he gradually introduced directive psychotherapy when his patient was ready for it and could accept it. This timing is, I believe, of the greatest importance and Dr. Clouse's perceptiveness in determining the patient's readiness for this step in therapy indicates, in my opinion, the great value of the physician's knowing his own patients. I feel there is a point at which directive therapy becomes the treatment of choice and that only the good clinician can recognize this point. We should remember that our very title of Doctor is derived from the Latin meaning "to teach."

To me, preventive Psychiatry is the most sophisticated form of medical treatment. I can easily envison Dr. Clouse's patient having become a chronic psychoneurotic with conversions in various areas accompanied by chronic depression, if she had not had the benefit of preventive care. In the prevention of invalidism and the prevention of unnecessary surgery which frequently prolongs and helps solidify the psychoneurosis, Dr. Clouse has done his patient a great service.

May we see more "how to do it" articles permitting more prevention, and with less invalidism. — WENDELL A. BUTCHER, M. D.

*These comments by Dr. Wendell A. Butcher were solicited by The Editor. Dr. Butcher is Chairman of the OSMA Committee on Mental Health.

WIDOWHOOD. — There are 8,815,000 widows in the United States. Metropolitan Life Insurance Company statisticians report that one out of every eight American women 14 years or older is a widow . . . and almost two of every three maintain a household, many of these with children. The figures based on the March 1965 estimates of the Bureau of Census, show that this country's widowed population has increased by nearly 870,000 in the past five years. There are now four times as many widows as widowers. A breakdown of the statistics on American widows shows that most of them are past midlife; one fifth of all women at ages 55 to 64 are widows; over two fifths between 65 and 74, and 70 per cent past 75.

At every period of life, it was noted, widowhood brings serious burdens. For instance, the burden is particularly heavy for women under 45 when three fourths of them with their own household have at least one young child in their care. And many widows past midlife have children under 18 in their home. Altogether, in 1960 about 900,000 widows faced this responsibility.

Over half the widows under 35 were reported employed or seeking work in 1960. The proportion was even higher — close to two thirds — at ages 35-54. Past midlife the proportion diminished. Even so, one seventh of the widows at ages 65-74 years were employed, many in part-time jobs.

Most widows still have many years ahead of them due to the favorable prospects of longevity among women. An American woman at age 50 can expect to live 20 years longer. The same number of years remain for nine tenths of those under 40. Almost three fifths of our women who are 65 can expect to live for 15 years and about one third for 20 years. — Metropolitan Life Insurance Company, NEWS RELEASE, July 26, 1966.

Hypersensitivity Diseases Of the Lung

A Review (Concluded)

JON P. TIPTON, M. D.

IN PART ONE of this review, asthma, the pulmonary infiltration with eosinophilia syndromes, Wegener's granulomatosis, and vasculitis involving the lung were discussed. Part Two will deal with pulmonary hypersensitivity associated with the inhalation of organic dusts, will include a discussion of sarcoidosis, tuberculosis and fungus infections, and will review the pulmonary manifestations of the major collagen diseases.

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Farmer's Lung

This syndrome is characterized by the development of a granulomatous interstitial pneumonitis following exposure to moldy hay, grain, fodder, or tobacco. The patients develop chills, fever, cough, and shortness of breath minutes to hours after exposure. Dyspnea may be extremely alarming and cyanosis may occur. Physical findings range from minimal change to respiratory distress with many crepitant rales and wheezes. The illness tends to run a course of seven to ten days with a gradual fall in fever and loss of symptoms. If it becomes chronic, following repeated exposure, interstitial fibrosis may develop.

Chest x-rays may show no changes or there may be extensive, diffuse, interstitial alteration with conglomeration of some areas to form patchy, pneumonic densities.

This disease is held to be caused by antigens in moldy hay which are produced by the action of the fungi on heated hay. Thermophilic actinomycetes are thought to be the important agents which appear in hay as it becomes heated in the course of molding. Of these actinomycetes, Pepys identifies polyspora as the most important. The antigenic stimulus produced by the action of these actinomycetes on the hay is so strong that 80 per cent of the affected patients develop precipitating antibodies in their sera. These precipitins are present against both the fungi present in good hay (i.e., Aspergillus, Cladosporium, Penicillium, Mucor, various Actinomycetes), bacteria in the hay, and the all-important antigens derived from the moldy hay. Contact with the various fungi or with good hay will not cause this syndrome to develop. Inhibition tests showed that the reactions to moldy hay extracts of the farmer's lung sera could only be inhibited by extracts of moldy hay and not by extracts of the fungi or of good hay.

Other Pulmonary Syndromes Associated with Organic Dust Inhalation

Bagassosis is a respiratory disease associated with the inhalation of dust from dried sugar cane fiber or bagasse. As the bagasse is usually baled and transported to industrial plants for a variety of purposes, including the production of paper and various types of building material, the number of workmen exposed is increasing. Thus, the disease is no longer limited to the sugar cane growing areas.

Patients suffering from this disease usually develop shortness of breath, a productive cough, chest pain, weakness, chills and fever, anorexia, weight loss, and frequently have night sweats. Histologically, they are found to develop a round cell infiltration of the interstitial tissue of the lung with thickening of the alveolar walls. There results a reduction in all components of lung volume and a degree of alveolar-capillary block. It is postulated that antigenic substances are formed in the bagasse by the action of fungi under appropriate conditions. Very old moldy bagasse has produced the most antigenically potent extracts. It is suspected that thermophilic actinomycetes probably serve as an important source of antigen in bagassosis, as they do in farmer's lung. Chronic bronchitis and fibrosis may develop if exposure is not curtailed.

Byssinosis is a syndrome found in textile workers and is related to exposure to cotton dust (pericarps and bracts). This disease process is interesting in that the patients are most symptomatic when exposed

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on Monday mornings after being away from the antigenic stimulation during the weekend. Major symptoms include fever, dyspnea, cough and wheezing. Chronic bronchitis and emphysema have been sequelae in some patients.

Maple-Bark disease is a disorder that affects both trees and man. Cryptostroma Corticale can be death-dealing to the sycamore tree. The hypersensitivity reaction in man to its spores causes a syndrome similar to farmer's lung. The disease has been found among workers engaged in peeling bark from maple and sycamore logs. Histologic studies have demonstrated numerous zones of cellular infiltration of the alveolar walls and disruption of the bronchiole walls. Extensive alveolar wall fibrosis, numerous granulomas and areas of focal histiocytosis with foreign body giant cells have been observed. As the spores do not grow at body temperature, this syndrome does not represent a true infection in man. High levels of precipitating antibodies have been found directed against antigenic extracts of the spores of C. corticale. This syndrome seems to involve both immediate and delayed types of hypersensitivity.

Sarcoidosis

This is a non-caseating granulomatous disease involving various organ systems. It is frequently called a disease of anergy. Sarcoidosis may be subacute, having a rather sudden onset in patients less than 30 years of age. In this type, one usually finds bilateral hilar adenopathy and associated erythema nodosum. These patients frequently have spontaneous remissions after three or four weeks. The chronic form is more insidious, occurring in both young and middle-aged patients. This type eventually involves more systems. These patients typically lose their delayed sensitivity (become anergic) but retain circulating antibody capability. The Kveim test is almost always positive.

By x-ray, one may find hilar nodes, soft patchy infiltrates, or diffuse fibronodular lesions with linear markings radiating from both hilar areas. Lesions may become confluent, assuming a snowball configuration. Healing fibrosis frequently develops in the lungs.

The exact etiology of this process is not yet definitely established. Studies by Buckley, Nagaya and Sieker revealed evidence of immunologic alterations other than impaired delayed hypersensitivity. Transient impairment of the response of lymphocytes cultured from patients with sarcoidosis to phytohemagglutinin stimulation was found to parallel the clinical severity of the disease process. A disproportionate increase in serum IgA was found and the hemolytic activity of serum complement was increased. They concluded that an altered immune response may be important in the pathogenesis of sarcoidosis.

As to etiology, the following hypothesis was formulated and postulated. It held that an infectious agent (i.e., mycobacteria) and altered immunity are both important in this process. Normally, susceptible individuals infected with phage-infested mycobacteria respond immunologically to both mycobacterial and phage antigens. The production of phage neutralizing antibodies impairs the effectiveness of the phage and permits infection with acid-fast bacilli. In such a case, typical tuberculosis results. If the patient lacks the capability to muster an effective immunologic response to the phage, typical tubercle bacilli do not develop. An altered phage-resistant mycobacterium analogous to a pleuropneumonia-like organism form develops. Areas of chronic inflammation develop as a result, which like the early phases of tuberculosis infections, are free of caseating necrosis and are not associated with tuberculin hypersensitivity. Clinically, typical sarcoidosis results.

They noted that the continued production of antibodies to mycobacteria by patients with sarcoidosis and the excretion of phage suggests that some form of symbiosis between the altered bacillus and the phage within the host cell must be achieved in which both persisting antigenic stimulation and phage replication are possible.

Background for this theory was derived from the work of Mankiewicz and van Walbeek, who demonstrated that patients with sarcoidosis and tuberculosis excrete large quantities of phage lytic for virulent mycobacteria in their stool. They noted that the patients with tuberculosis have high titers of neutralizing antibodies for lytic phage in their sera while those with sarcoidosis have little or none.

For many years, the literature has been preoccupied with the pro's and con's of loblolly pine pollen as a possible factor in the etiology of sarcoidosis. These theories have been based on the apparent direct relationship of sarcoidosis incidence and the density of the loblolly pine forests. In addition, laboratory workers have been able to produce granulomata in mice and guinea pigs following intranasal instillation of suspensions of loblolly pine pollen. Other studies have reported a significant proportion of the population residing in so-called pine belts exhibited delayed skin reactions to a purified protein preparation of pine pollen, while sarcoidosis patients revealed a decreased index of skin reactivity consistent with the depression of delayed hypersensitivity. Patients with sarcoidosis are held to have an abnormally efficient production of circulating antibody in the face of impaired delayed hypersensitivity. Ten to 15 per cent of these patients have hypercalcuria in addition to the increased gamma globulin levels. Antinuclear antibodies have not been demonstrated.

Systemic Lupus Erythematosus

This collagen disease involves most organs and results in the homogenization and eosinophilic staining of the ground substance with thickening and straightening of the connective tissue fibers. Serous membranes are affected with fibrous deposition and fibrosis. Pulmonary involvement is frequent but its pathology is not characteristic.

Common pulmonary findings are interstitial inflammatory lesions with associated atelectasis. The interstitial pneumonia consists of alveolar wall exudate and swelling of the septa. This process is said to occur diffusely in 44 per cent of the patients and focally in 9 per cent. Mucinous edema occurs in about 10 per cent of the patients and is characterized by a basophilic appearance (H & E) of the connective tissue of the peribronchiolar, perivascular, or interstitial tissue.

More commonly, terminal bronchopneumonia, hemorrhages or pleural effusions occur. Some estimate that fibrinous pleuritis occurs in 50 to 75 per cent of the cases. Thoracentesis is rarely necessary. Lupus infiltrates may persist for months without change. X-ray findings including multiple plate-like areas of atelectasis at the bases, elevation of the diaphragm and pleuritis are frequently seen in SLE. Arteritis of pulmonary vessels may result in hemoptysis, cavity formation, or lung abscesses if secondary infection occurs.

The peripheral leukocyte count is usually normal or depressed. About 15 per cent of the patients with SLE show biologic false positive tests for syphilis, frequently years before a diagnosis of SLE can be made by any other criterion. This, plus the presence of high titers of antibodies in all three main immunoglobulin classes at the onset of clinical SLE, implies that antigenic stimulation precedes the overt disease by a prolonged period.

Positive LE preparations are found in approximately 80 per cent of these patients. The antinuclear factor has been detected in IgG, IgM, and IgA immunoglobulin classes. Immunofluorescent studies have been done endeavoring to show specific antibody to nucleoprotein, to deoxyribonucleic acid (DNA), and to a phosphate-extractable protein of the nucleus. These studies have been inconclusive. Substances with nuclear antigenicity are not limited to tissue nuclei, but may be demonstrated in the blood stream as well. It is thought that antinuclear antibodies may play a role in the progression of the already established disease state if they interact with their respective antigens in the hosts' tissues.

Progressive Systemic Sclerosis

This is a systemic disorder of connective tissue characterized by inflammatory, fibrotic, and degenerative changes in the skin, synovium, and certain internal organs, notably the heart, gastrointestinal tract, lung and kidney. The fundamental nature of its etiology remains obscure. Women are affected twice as often as men. This process generally first presents between the ages of 30 and 50. There has been a high incidence in workers exposed to silica dust.

Pulmonary involvement in this disease is of importance. The elastic tissue of the alveolar walls is replaced by collagen fibers, as is that of the interstitial areas. Endarteritis, medial hypertrophy, and intimal proliferation have been described. The pulmonary fibrosis results in a decrease in the size of the lungs. The involved lobes are referred to as being leathery. Small subpleural cysts are encountered with some frequency. Extensive fibrous pleurisy may be present, especially in the lower portion of the lungs. Bronchial involvement consists of fibrous replacement of the muscular coats of some of the smaller bronchi with resultant bronchiolar dilatation.

It is believed that hyaline changes occur first, followed by diffuse parenchymal fibrosis. Obliteration of the capillaries by interstitial fibrosis leads to degeneration of alveolar walls and cystic areas in relation to the bronchioles. Alveolo-capillary block often results from the interstitial proliferation and the alveolar wall changes. The lung fibrosis plus fibrosis and induration of the thoracic skin combine to produce a restrictive pulmonary function pattern. To compensate for the increased oxygen gradient, these patients tend to hyperventilate and may be mildly alkalotic due to the ready diffusibility of carbon dioxide.

There is variable sclerosis of the smaller pulmonary vessels. Chest roentgenograms may show diffuse or localized fibrosis or nodulation, or subpleural cystic changes. Occasionally, calcification is seen within the lung.

Approximately half of the patients with P. S. S. have hypergammaglobulinemia. Studies of the sera reveal antinuclear globulins in a high percentage of the cases. Beck reported this finding in 78 per cent of cases studied. Some of these patients have positive LE preparations without evidence of that disease. Over half seem to have positive hemagglutination and latex agglutination reactions. Complement levels have been reported as normal although some postulate that the sera of certain patients exert an inhibitory effect on complement fixation reactions. A familial basis is rare.

Rheumatoid Arthritis

This collagen disease occurs in 2 per cent of our population. Pulmonary involvement is rare and nonspecific. However, it is becoming apparent that interstitial disease of the lung has more than a coincidental relationship with rheumatoid arthritis.

In this condition, the lungs may be decreased in size, depending on the degree of interstitial fibrosis. One may find dense, pleural adhesions, fibrinous pleuritis and pericarditis. Nodulation and diffuse fibrotic scarring may be present. Occasionally, one finds a typical rheumatoid nodule. Vascular lesions are infrequent.

Clinically, fever, cough, dyspnea and occasionally cyanosis exacerbate with bouts of arthralgia. The syndrome may resemble primary atypical pneumonia. Pleural effusions may develop.

Sullivan found pulmonary fibrotic lesions in six of 100 autopsies of patients with rheumatoid arthritis. In comparison, only 16 of 16,000 random autospied

patients had this finding. Some postulate that these patients are hypersensitive and over-react to coal dust, silica and other irritants with resultant connective tissue changes. This disease process combines humoral hypersensitivity of the arthus and cytotoxic types.

Other Pulmonary Diseases Involving Hypersensitivity

Pulmonary tuberculosis, although too large a subject for adequate discussion in this article, represents the infection type of cellular hypersensitivity. This process is produced by Mycobacterium tuberculosis. It has been discovered that, in addition to delayed hypersensitivity, humoral antibodies develop in response to the same antigenic stimulus. A third immunologic factor involves the production of a degree of acquired resistance which is implied from the ability of infected subjects to contain or localize the process. On re-infection, this enables the patients to localize the infection to the area in which it begins without lymphatic involvement.

The cells generally considered to be the alternatives for antibodies as instruments of acquired immunity in tuberculosis are the macrophages. These cells possess the ability to engulf the mycobacteria (without inevitable death to the macrophage).

The cells directly implicated in delayed hypersensitivity by most workers are the lymphocytes. Some believe there are developmental relationships between the lymphocytes and the macrophages. An important aspect of the pathogenesis of tuberculosis is the pronounced tendency of the cellular lesion at the time of appearance of the immunological responses (about three to four weeks from the time of infection) to undergo necrosis. During this phase, the number of bacteria in the lesion is likely to decrease considerably. Tissue enzymes usually do not attack the dead tissue. Thus, it retains a relatively solid consistency, being described as caseous. These lesions most often heal with fibrosis and deposition of calcium. Eventually, they contract to a scar. This granulomatous lesion plus pulmonary lymphatic and hilar node involvement form the classical Ghon complex of primary tuberculosis.

Humoral antibodies can be identified by complement fixation, agar gel diffusion and hemagglutination tests. The antibodies are elaborated against proteins and polysaccharides and, perhaps, against certain lipids of the mycobacteria. Kochan describes a tuberculostatic factor in the serum of healthy humans. Inorganic phosphate and citrate, which are present in "tuberculous" media were found to be antagonistic for the tuberculostatic activity of the factor. Also, the tuberculostatic factor could be removed from the sera by repeated adsorptions with heavy suspensions of tubercle bacilli. This factor is present in the sera of both tuberculin negative and tuberculin positive patients and is thought to be native and not acquired. It is doubtful if humoral factors are related to acquired immunity against the disease.

Delayed or cellular hypersensitivity is classically passively transferred only via mononuclear cells (i.e., lymphocytes) and not in the serum or plasma. Recent investigations have demonstrated a "transfer factor" which may be released from the cells into a cell-free substrate if the hypersensitive lymphocytes are physically disrupted. A release or liberation of the same kind of specific material from the hypersensitive lymphocytes has been demonstrated in vitro following exposure to specific antigen. The involved lymphocytes appear to become desensitized.

Other pulmonary disorders with hypersensitivity factors include fungus infestations which, for the most part, involve both humoral and delayed hypersensitivity mechanisms.

Conclusion

The major pulmonary disorders with a hypersensitivity basis or component are reviewed. Humoral, cellular and combined forms of hypersensitivity have been described as the immunologic basis for the varying disorders. The most current theories concerning the immunologic mechanisms are presented.

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CHRONIC LYMPHOCYTIC LEUKEMIA. — The cooperation of physicians is requested in a continuing study of chronic lymphocytic leukemia, including therapy in patients with this disorder, being conducted by the Medicine and Radiation Branches of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland. Referrals of selected patients, particularly those with high circulating lymphocyte counts, are needed.

Physicians interested in having their patients considered for the study may write or telephone: Ralph E. Johnson, M. D., Clinical Center, Room B1B-41B, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 656-4000, Ext. 65457. — ANNOUNCEMENT, Clinical Center, NIH, September 1966.

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MALIGNANT LYMPHOMA. — The cooperation of physicians is requested in a study of lymphosarcoma and reticulum cell sarcoma in children and young adults. This study is being conducted by the Medicine Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

All clinical stages of biopsy-proven disease are acceptable, and untreated patients are preferred. Slides of pathologic material must be submitted for review before patients can be accepted.

Of particular interest are those patients with clinical and histologic features similar to the malignant lymphoma of African children (Burkitt tumor). These patients generally present with jaw, ovarian, or abdominal masses. The purpose of this study is to conduct immunologic, virologic, pathologic, and chemotherapeutic studies.

Suitable patients will be admitted to the Clinical Center in Bethesda, Maryland, or to one of the participating medical centers. Physicians who wish to have their patients considered for the study may write or telephone: John L. Ziegler, M. D., Clinical Center, National Institutes of Health, Building 10—Room 12-N-226, Bethesda, Maryland 20014; Telephone: 656-4000, Ext. 64251, (Area code 301). — ANNOUNCEMENT, Clinical Center, NIH, October 1966.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

PRESENTATION OF CASE

THIS white male truck driver, aged 28, was admitted in shock to University Hospital. While playing baseball two days prior to admission the patient experienced the sudden onset of severe pain in the throat and neck, followed shortly by radiation of pain down the back into the legs. He was taken to his local hospital and was found to have a blood pressure of 210/90. Later the same day he developed severe cramping abdominal pain followed by several large bloody stools and vomiting. He continued to complain of intermittent cramping abdominal pain, became febrile, developed tachycardia, and his blood pressure fell to 80/50, requiring pressors. The patient became progressively shocky and confused. He was treated with oxygen, intravenous fluids, penicillin, and streptomycin. Because of his rapid deterioration he was transferred to University Hospital for further evaluation and therapy.

Prior to this acute episode the patient had been in moderately good health. Five months prior to admission he was found to be hypertensive with his blood pressure recorded at 190/120. He was started on antihypertensive therapy but never returned for follow-up care. He had also had mild epigastric pain and pyrosis for several years, relieved by Rolaids®. Otherwise the past history and the review of systems were not contributory.

Physical Examination

The patient was moderately obese, acutely ill, confused, cyanotic, and in obvious shock, with a pulse rate of 140 per minute, a systolic blood pressure of 60, and a temperature of 105.6°F. His skin was cool and clammy. Examination of the head, eyes, ears, nose and throat revealed no abnormalities. Funduscopic examination was not recorded. The neck was supple; no venous distention was noted; carotid pulsations were present; no bruit were noted. The thyroid was not enlarged. The lungs were clear to percussion and auscultation. The heart had a regular tachycardia and no murmurs or cardiomegaly were found. The abdomen was obese, rigid, and diffusely tender with rebound tenderness; no bowel sounds were heard; no organomegaly was noted. Rectal examination revealed grossly bloody stool. The extremities were cool on touch and there was mottling of both legs. No pulses were palpable below the femoral arteries. The neurological examination was noteworthy only for the disoriented, confused mental status of the patient.

Submitted September 17, 1966.

Presented by

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Edited by Dr. von Haam.

Laboratory Data

On admission, the hematocrit was 53 per cent, the hemoglobin 18.2 Gm., the white blood cell count 26,000 with 33 per cent nonsegmented and 63 per cent segmented polymorphonuclear leukocytes and 4 per cent lymphocytes. Serum chemistries on admission revealed a CO_2 combining power of 33 mEq., sodium of 142 mEq., potassium 4.6 mEq., and chlorides of 92 mEq. per liter; amylase 132 units; direct bilirubin 2.2 mg. and total bilirubin 3.3 mg. per 100 ml. The blood urea nitrogen was 60 mg. per 100 ml. The prothrombin time was 46.2 per cent of normal. An electrocardiogram revealed a right interventricular conduction defect, sinus tachycardia, and broad P-waves.

An anteroposterior recumbent x-ray film of the chest revealed possible cardiomegaly and normal lungs. The abdominal films were compatible with an adynamic type of ileus.

Hospital Course

On admission the patient was acutely ill with sepsis and shock. His abdomen was tapped and the fluid obtained revealed 19,500 red blood cells and 47,000 white blood cells with 90 per cent neutrophils. Gram stain of the abdominal fluid revealed numerous bacteria, both cocci and rods. Amylase on the abdominal fluid was 1600 units. The patient was started immediately on intravenous replacement therapy and antibiotics. Four hours after admission

his temperature was 99.6, the pulse 116, and his blood pressure 140/70. The urine output was 15 ml. per hour; the specific gravity of the urine was 1.025. During this period he had received 7 liters of fluid including 2,800 ml. of Albumisol® and 12.5 Gm. of mannitol. He also received large doses of Chloromycetin® intravenously and was treated with Solu-Cortef®, 100 mg. intravenously every six hours.

After the initial period of fluid replacement his condition seemed somewhat stable, and eight hours after admission an abdominal exploration was performed. Following surgery he continued on a downhill course. His urinary output continued to decline and he became anuric 12 hours after surgery. He was again taken to surgery and femoral catheters were inserted for hemodialysis. Postoperatively, he continued to have rectal bleeding and bloody drainage from the Levin tube. While being prepared for hemodialysis 48 hours after admission the patient had a precipitous fall in his blood pressure with respiratory-cardiac arrest. Resuscitative efforts were to no avail.

CLINICAL DISCUSSION

DR. GOODMAN: I think at first that we ought to summarize a few essential points. This was a 28 year old truck driver who had an acute and severe pain in his throat and neck which radiated to his back and into both legs. He was known to be hypertensive. He became febrile, developed tachycardia, went into a shock-like state, and was referred to our hospital. He had been in relatively good health until five months ago, when he was found to be hypertensive and gave a history of having mid-epigastric pain and pyrosis. He was admitted to the hospital in obvious shock with a rapid pulse, a low blood pressure, and fever. His abdomen was obese, rigid, and there was certainly evidence of peritonitis. He also had grossly bloody stool. His legs felt cool, and no pulses were felt below the femorals. The laboratory data are not too revealing for his state at that time. His electrocardiograms suggested left ventricular hypertrophy and a possible conduction defect.

Discussion of X-Rays

Before we continue I think we ought to take a look at his x-rays.

DR. DUNBAR: I do think that his heart is large and that his left ventricle is bigger than it should be. I also feel that his aorta is wide for a 28 year old man, and I would be happy with the diagnosis of some type of cardiovascular disease. The abdomen shows small bowel distention with fairly thick walls.

DR. GOODMAN: What's the significance of the thickness of the bowel wall?

DR. DUNBAR: Boggy, edematous small bowels are quite common in either venous or arterial thrombosis and mesenteric infarction. It could also be just peritoneal fluid between the loops.

DR. GOODMAN: Is there any evidence on the chest film of coarctation or dissection of the aorta?

DR. DUNBAR: No, I see no rib notching and no evidence of the fuzziness which we get with mediastinal hematoma.

DR. GOODMAN: Do you think there is widening of the arch of the aorta or anything that would suggest aneurysmal dilatation?

DR. DUNBAR: The aortic arch is wider. If he were a 50 year old man I could not say that this was abnormal, but for a 28 year old man I don't think the aortic shadow should be as wide as this is.

DR. GOODMAN: This man was acutely ill. They were able to stabilize him with fluids and albumin, and once he was stable the surgeons felt they should operate. So they explored the patient. He didn't do well. Hemodialysis was attempted. He became anuric and died.

An Obese First Baseman

I would now like some information regarding the body size of this man. Was he tall and thin, short and fat, or what do we know about his stature?

DR. THOMPSON: There is no mention on the chart other than that the patient was moderately obese.

DR. GOODMAN: I would like to take you through my thought processes as I first read this protocol. The first thought that entered my mind: Here was a young fellow with an acute onset of pain, and in any young individual with a pain in his neck radiating down his back to his legs one must certainly be concerned with an acute vascular accident, and the first diagnosis that entered my mind was that perhaps we are dealing with a ruptured aneurysm in a hypertensive individual.

If we assume a ruptured aneurysm, we are forced to ask the questions, Why? and What type of aneurysm did he have? It could have been congenital, syphilitic, arteriosclerotic, mycotic, traumatic, or embolic. You can rule out a number of these by his history, etc., but you certainly can't rule out the possibility that he had a congenital aneurysm or an arteriosclerotic aneurysm, or perhaps even an aneurysm that was precipitated by his playing baseball. Did he experience any trauma to his abdomen or chest at the time he was playing baseball?

DR. THOMPSON: Apparently this came on during a baseball game and he didn't experience any trauma. He was playing first base when this happened.

DR. GOODMAN: Let us assume for the present that this man did have a ruptured aneurysm and make the further assumption that we may be dealing with an arteriosclerotic aneurysm. The most common site of such an aneurysm is at the iliac bifurcation. It is usually below the renals and this would certainly account for the findings of decreased pulsations below

the femoral pulses and could account for his symptoms of pain in the neck with radiation down. He could have had dissection with subsequent rupture. Now we must ask ourselves, Could this man have had Marfan's syndrome? Sudden death in a young individual with a possible vascular accident as the factor always suggests Marfan's syndrome.

I really wasn't so pleased with my first impression because I became concerned with his abdomen, and here we find that he did have evidence of a peritonitis with blood in his stools, and we could explain this on the basis of an aneurysm which had ruptured into the gastrointestinal tract. I think it is rare, but it has been reported. So we could lump everything together and explain it in this way.

Mesenteric Vessel Disease?

The next thing that we have to consider is that something went wrong with the mesenteric artery — either a thrombosis or an embolism — and perhaps one might even be intrigued with the idea that this man had mesenteric artery insufficiency, because of the symptoms he gave earlier of pyrosis and mid-epigastric pain, though at the same time perhaps these symptoms could have been due to a peptic ulcer. When we speak of mesenteric artery disease we must be aware that this occurs in all ages, but it is much more common in older individuals and much more common in men. It need not be the mesenteric artery; it could be the mesenteric vein. But by and large, when you are dealing with thrombosis of a mesenteric vein you are very much concerned with infections in the neighboring organs, such as the appendix, colon, and the pelvic organs. When you think in terms of a thrombosis affecting the mesenteric artery you are much more concerned with arteriosclerosis, endocarditis, polyarteritis, and even thromboangiitis obliterans.

As long as we think about the mesenteric artery we must ask ourselves, Was this an acute or chronic affair? There is some indication, if we want to put emphasis on the earlier symptoms, that he could have had a chronic mesenteric artery insufficiency, but I would like to consider this more as an acute episode. The symptoms of acute mesenteric artery thrombosis could be identical to what he had — pain in the abdomen, increased temperature, increasing white count. His entire course of shock, increase in hematocrit, diminished blood volume, and the anuric state he went into could be due to a mesenteric artery disease.

But once again we have to raise other questions. What else could simulate an acute vascular accident involving the abdomen? Similar symptoms are found in acute pancreatitis, in traumatic pancreatitis, or in a perforated viscus. As far as perforation of a viscus is concerned, we have no evidence on x-ray that he had any free air under his diaphragm though we do have a history of a possible peptic ulcer. If he had a pancreatitis the chances are that the serum amylase would have been elevated, and it was not in this case. He did have an increase in the amylase in his peritoneal fluid and we certainly can find this in mesenteric artery disease.

Hypertension

Let's now try to answer the most basic problem of this case: Why was this man hypertensive? The protocol says, "A funduscopic examination was not recorded." I can assume that it wasn't done. If one had looked at his eyegrounds one could have come to some conclusion as to the duration and severity of his hypertension and maybe as to its cause. Certainly whenever you have a hypertensive individual you should examine his eyegrounds. Let's discuss a few possibilities of his hypertension. One intriguing possibility is that perhaps this man had a coarctation of his aorta and that his femoral pulses were diminished all along. But we have no evidence of this and I consider this possibility as very remote. Perhaps he had a pheochromocytoma with sudden onset of hypertension. He could also have had any type of renal disease, or just essential hypertension which went into the malignant phase.

Well, I am about to commit myself now. I think we are dealing here with a man who had an acute vascular accident. This accident certainly involved his gastrointestinal tract. I think that perhaps one of the most likely would be rupture of an aneurysm and I pick this because he had pains radiating into his neck, down his back, and into his legs. If we are just dealing here with an isolated mesenteric artery thrombosis, I would be very surprised to find these symptoms. So I would think that we are dealing here with a man who had a dissection and rupture of an aortic aneurysm and that this aneurysm may very well have subsequently involved the mesenteric artery with occlusion or have ruptured into the gastrointestinal tract producing the symptoms of blood in the G. I. tract and subsequent peritonitis.

Why he had hypertension I don't know, and I really don't think it does any good to speculate more about it. I suppose I could say perhaps the sudden onset may mean that he had a pheochromocytoma, but we really have very little to speculate on. And behind it all lies the possibility that perhaps we are dealing with a Marfan's syndrome with dilatation of the arch of the aorta and rupture. I would call your attention to the fact that not all Marfan individuals are tall and thin; they can be obese, but this is rare.

General Clinical Discussion

DR. PERKINS: I have seen a few reports of silent dissection of the aorta and I wondered if it could have happened some time in the past in this man, resulting in hypertension, and a delayed rupture caused his acute episode.

DR. GOODMAN: I think that's a good possibility.

DR. HARRIS: You say "aneurysm." Couldn't you be a little more specific about that?

DR. GOODMAN: I would think probably that this was a dissecting type of aneurysm and that he dissected earlier and that he didn't really rupture a true aneurysm.

DR. HARRIS: Could you suggest any particular site in the aorta for the rupture? Why did he die so suddenly?

DR. GOODMAN: This dissection could well have started in the arch of his aorta or in the ascending portion, dissected all the way down and ruptured into his abdomen. If you take the group of people with dissecting aneurysm below the age of 40, 20 per cent of them will have Marfan's syndrome and only about 9 or 10 per cent will suffer from coarctation of the aorta. By the way, we should mention that a very common cause of dissecting aneurysms in women is pregnancy, and this is why women ought to be excluded from any statistics.

STUDENT: I would just like to take advantage of one fact Dr. Thompson gave us a few moments ago and that's that the man was playing first base. This would suggest a person with a long reach. I would like to ask Dr. Goodman what Marfan's syndrome is.

DR. GOODMAN: It is really a collection of several manifestations occurring in individuals suffering from an inherited defect of connective tissue development. It particularly affects the aortic arch with weakening of the media of the aorta leading to dissecting aneurysm or aortic regurgitation, and it also produces ectopia of the lens, all probably due to weakness of the connective tissue. An individual with the Marfan's syndrome may have one or all of these manifestations.

CLINICAL DIAGNOSIS

1. Dissecting aneurysm of the aorta.
2. Mesenteric artery disease with thrombosis and hemorrhage.
3. Generalized peritonitis.

PATHOLOGICAL DIAGNOSIS

1. Medionecrosis of the aorta with ruptured dissecting aneurysm.
2. Compression of the inferior mesenteric artery with thrombosis, and infarction of the small intestine.
3. Acute peritonitis.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: First we would like to find out from Dr. Thompson what surgical procedures were performed.

DR. THOMPSON: Since the patient presented an acute surgical abdomen they felt that it had to be explored. When they opened the abdomen they did discover diffuse peritonitis. They also found numerous loops of small bowel which appeared dark and showed questionable viability. They removed two small areas of necrotic bowel. The stomach was filled with blood clots and a small bleeding ulcer was found at the cardio-esophageal junction.

DR. VON HAAM: At the autopsy we found a rather tall man measuring 6 ft. 4 in., weighing about 300 lbs. There was no specific disproportion of the length of the extremities, nor were there other gross characteristics present commonly associated with Marfan's syndrome. The heart weighed 450 Gm. and showed left ventricular hypertrophy. The aorta had dissected through a slit 5 mm. above the valve. A minimal amount of seepage had occurred into the pericardial cavity (70 cc.). A seepage of 200 cc. had occurred into each pleural cavity, and about 500 cc. of blood had infiltrated the retroperitoneal space. The dissection of the aorta had progressed to the femoral arteries, causing stenosis and thrombosis of both vessels. The renal arteries were free of dissection. The mesenteric artery showed a severe compression of the lumen by the dissecting aneurysm with recent and complete thrombosis.

Microscopic sections showed necrosis and severe mucoid degeneration of the media of the aorta with splitting of the media and recent dissection. The bleeding ulcers in the stomach were of the type commonly found in acute stress with superficial necrosis of the mucosa and seeping hemorrhage. Much of the remaining bowel showed recent necrosis due to complete ischemia. No pheochromocytoma was present, but a small cortical adenoma was found in one adrenal gland. The kidneys showed no evidence of advanced vascular disease but did show ischemia of the glomeruli compatible with shock.

So in summary, we have an individual who had some but not all the constitutional characteristics of Marfan's syndrome with medionecrosis of the aorta and extensive dissection. I think the dissection probably had been going on for some time and we estimated its duration at four to six days. The patient died from acute intestinal infarction due to mesenteric artery thrombosis with diffuse peritonitis.

IN 168 COAL MINERS, peptic ulcer was observed in 18.5 per cent. There was no difference in the occurrence of peptic ulcer in patients with or without pulmonary disease in chest x-ray and pulmonary function tests. — Edward M. Schneider, M. D., *Clinical Medicine,* 73:69-71, March 1966.

Maternal Deaths Involving Suicide*

By the OSMA COMMITTEE ON MATERNAL HEALTH

With Comment of Consulting Psychiatrist

THE files of the Committee on Maternal Health, Ohio State Medical Association, contain approximately 1,025 cases for nine years, 1955 to 1963, inclusive. In ten of the cases the cause of death is related to suicide associated with the pregnant state. Eight of the ten have been voted *nonmaternal* deaths (no connection with pregnancy) while only two were considered *maternal* deaths. Herewith the Committee presents three cases, two of which are maternal deaths; the third was classified a nonmaternal death.

Case No. 533

The patient was an 18 year old, white, Para II, who died from asphyxia ten days postpartum. Her general past history was not remarkable, neither was the specific history concerning emotional or psychiatric disturbances. However, in her sixteenth year the patient had delivered a pregnancy at term without any obstetric complication; she was married during the second gestation. The family physician with whom she registered in the seventh month, in retrospect concluded that the patient might have developed a "guilt complex" originating in circumstances surrounding either or both of the two pregnancies.

Prenatal care for the second pregnancy revealed no abnormalities; serologic test for syphilis was negative, and her blood was Rh positive. On November 27 (42 weeks gestation) labor began spontaneously and the patient was admitted. Premedication consisted of Demerol® and scopolamine. Membranes ruptured spontaneously and after a six and one-half hour labor the patient delivered a living term fetus (weight not stated) under a general anesthesia, administered by a registered nurse. No lacerations were incurred; blood loss was estimated at 200 cc., and the third stage was normal.

The following day she was discharged to her mother's home at her own request. Her physician made two routine visits (November 30 and December 4) reporting her puerperal course to be uneventful. Later the patient's mother revealed that the daughter seemed slightly vague on or about December 5 (8 days postpartum) stating that she "must go home" (to her abode, approximately two miles away). Further, that the patient insisted on getting all the work done before she would leave. On December 5 or 6 the patient's mother considered advising the physician of the unusual behavior, but neglected to do so. Later, on December 6 and 7, the family missed the patient; further search revealed she had trudged through ice and snow to her mobile-home. Her body was found (fully clothed) submerged in a nearby creek.

Cause of Death (Coroner's Autopsy): Asphyxia by drowning.

Comment

The case was studied at great length by the Committee. All available facts were discussed in detail. It was assumed that the patient had developed a postpartum psychosis, based upon predisposing factors presented in the history. After prolonged deliberation, by a narrow vote, members voted the case a nonpreventable maternal death. Nearly a majority believed the mother might have secured valuable assistance from the physician had she advised him promptly of her daughter's behavior.

Case No. 595

This patient was a 26 year old, white, gravida II, Para I, who died undelivered of carbon monoxide poisoning, in the thirty-sixth week of gestation. Little information is available concerning her past history; however, from various sources it was elicited that she had episodes of emotional disturbances in the past. The previous pregnancy was delivered in 1958, at term without any known obstetric complications. Her child's pediatrician states she made regular visits with the baby who developed a succession of complicated illnesses. This physician, who also attended neighbors of the deceased, stated that they regarded her as "seriously upset" over prospects of bearing another child. She had no prenatal care during the last pregnancy.

On February 16 (about eight months gestation) the patient's husband awoke to discover her dead in the front seat of the family car. Allegedly she had attached a garden hose to the exhaust, led the other end into the car, and started the motor.

Cause of Death (Coroner's Autopsy): Carbon monoxide poisoning; suicide.

Comment

Realizing that only meager facts were available in the case, the Committee studied the data with great interest. Emotional features possibly precipitated by the ill-health of her first-born child were discussed at great length; the vague facts concerning previous anxiety states were considered carefully. Members felt that these potential factors, together with certain physiologic changes associated with pregnancy, formed

*A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

the basis for a diagnosis of psychosis of pregnancy. By a majority vote the case was voted a nonpreventable maternal death.

Case No. 891

The patient was a 22 year old, white, gravida I, who died undelivered, 28 weeks gestation, from a self-inflicted bullet wound of the heart. Her past history is noncontributory. She registered with her family physician in the third month of pregnancy, and made nine prenatal visits. Blood type was O positive, serologic test for syphilis was negative; the physical examination was grossly normal. Her prenatal course was uneventful until the fifth month when she displayed signs of tension and emotional disturbance, withholding all information regarding the cause. Frequent visits to her physician (six or more) were then made at intervals in futile attempts to investigate and treat the basis of the patient's distress. The last such visit was made at twenty-eight weeks gestation (January 3) when the physician recorded "she appeared much improved and reported subjective improvement"; the next appointment was scheduled in two weeks.

On arriving home one night, the husband discovered the body of his wife.

Cause of Death (Coroner's Autopsy): Bullet wound of the heart; hemopericardium 200 cc.; bullet wound of the left lung; hemothorax 1800 cc.; bullet wound of left thorax; gravid uterus, seven month fetus; suicide.

Comment

Members of the Committee studied available information surrounding the tragedy, and analyzed details supplied by the physician of the patient. After due deliberation it was felt that the pregnancy was not related to the death either directly or indirectly. The case was voted a nonmaternal death.

Comment of Consultant

The following comment of a consultant, who is a specialist in Psychiatry, was given at the request of the Committee:

"Suicide is a subject few physicians like to consider. Death represents an individual failure to us, and when there is added the realization that one of our own patients has decided to kill herself and has carried out her decision, most of us avoid considering it with all the emotional rationalization at our command. For this and other reasons, such as the possible abrogation of insurance payments, fear of the effect such knowledge might have on surviving relatives and friends, and religious considerations, many suicides are glossed over as natural deaths, and I feel that any group of statistics involving suicide rates are inconclusive. They cannot, therefore, be used as we ordinarily use statistics in the practice of medicine. Even so, suicide is known to be one of the ten most frequent causes of death in the United States today.

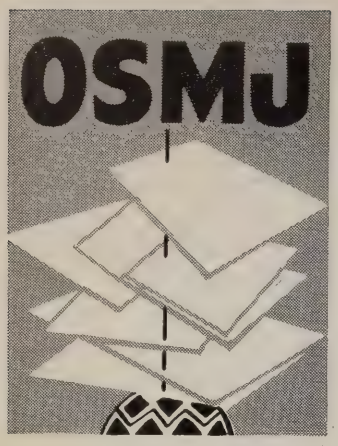
"Prevention of death, whether it be due to an uncontrollable postpartum hemorrhage or to an uncontrolled postpartum depression, is the ultimate concern of every physician. The three foregoing case histories make the point that the obstetrician should be fully aware of the signs and symptoms of depression and their implications. He should also know the available weapons in our therapeutic armamentarium.

"However, it is imperative that relatives, friends and persons with whom the patient associates, be alerted to notice early signs, or symptoms of unusual behavior and report them to the patient's physician or other proper source. Tensions, demonstrable as nervous or emotional disturbances, as well as peculiarities in behavior or habits are among the important signs to be noted.

"No pregnant woman is without some depression, which can be intensified by environmental factors or by emotional immaturity. Endocrinologically, the postpartum period resembles the menopause. The cornerstone of obstetrical psychotherapy is a strong, supportive doctor-patient relationship. This entire journal could be devoted to the discussion of the three cases in their relationship to these principles, and to the art and science of the recognition of the signs of depression and their implications. The space allotted does, however, permit the plea that every primary-care physician avail himself of whatever training he can obtain, be it through reading, through seminars, or, preferably, through postgraduate training of a clinical nature. I feel that depression is probably the most common disease encountered by the physician."

ABORTION AND THE PSYCHIATRIST. — A study of 213 patients with puerperal psychosis showed that the condition carries a good prognosis and is virtually unpredictable. Instability in pregnancy does not contribute materially to the incidence of puerperal psychosis. Suicide is less of a risk in pregnant women than in nonpregnant women. Unmarried mothers are relatively immune from puerperal psychosis. Abortion, even if therapeutic, may in itself produce a psychosis.

There are no psychiatric grounds for the termination of pregnancy. Pressure may be brought to bear on the psychiatrist to recommend termination. He may be told the patient is threatening suicide or be regaled with the dreadful social consequences. The answer is still not to recommend termination, which may indeed be harmful, but to nurse the patient through her unstable phase. — Myre Sim, M. D., Birmingham, England: *British Medical Journal,* p. 145, July 20, 1963.



NEWS AND Organization Section

Proceedings of The Council...

Statements of Policy Regarding Utilization Review Committees, And Assignment Under Medicare Are Drafted in Special Session

THE COUNCIL of the Ohio State Medical Association met at the Fort Hayes Hotel, Columbus, Ohio, 8:30 A. M., October 23, 1966. Those present were: Drs. Lawrence C. Meredith, Elyria, President; Robert E. Howard, Cincinnati, President-Elect; Henry A. Crawford, Cleveland, Past President; Philip B. Hardymon, Columbus, Treasurer; Paul N. Ivins, Hamilton; Theodore L. Light, Dayton; Robert N. Smith, Toledo; P. John Robechek, Cleveland; Edwin R. Westbrook, Warren; Sanford Press, Steubenville; Robert C. Beardsley, Zanesville; Oscar W. Clarke, Gallipolis; Richard L. Fulton, Columbus; and William R. Schultz, Wooster. Others attending the meeting were: Drs. John H. Budd, Cleveland, and Robert E. Tschantz, Canton; Mr. Wayne E. Stichter, Toledo, OSMA Legal Counsel; Mr. James Kline, Offices of the General Counsel, Toledo; and Messrs. Page, Edgar, Campbell and Moore of the OSMA staff.

The Council developed statements, concerning the method of billing patients under Titles XVIII and XIX of Public Law 89-97, and with regard to Utilization Review Committees of Hospitals and Extended Care Facilities.

The Council then recessed for a discussion program with the Presidents, Secretaries, and Hospital Relation Committee Chairmen of county medical societies, members of the OSMA Committee on Government Medical Care Programs and the Committee on Hospital Relations, and Executive Secretaries of certain county medical societies.

Subsequently, the Councilors met with the members of each district and the policy statements were reviewed and many suggestions were volunteered for incorporation in the finished statements.

Council then recessed until 1:30 P. M., October 26, 1966. It met in the Board Room of the Huntington National Bank Building, 17 S. High Street, Columbus. Those present were: Drs. Meredith, Howard, Crawford, Hardymon, Ivins, Light, Westbrook, Beardsley, and Fulton. Also present were: Mr. Wayne E. Stichter and Messrs. Page, Gillen, Traphagan and Moore.

Billing Methods Under Title XVIII and Title XIX

By official action, the following policy was adopted as a "Statement of Position of The Council of the Ohio State Medical Association Regarding the Method of Billing Patients Under Titles XVIII and XIX of Public Law 89-97":

STATEMENT OF POSITION OF THE COUNCIL OF THE OHIO STATE MEDICAL ASSOCIATION REGARDING THE METHOD OF BILLING PATIENTS UNDER TITLES XVIII AND XIX OF PUBLIC LAW 89-97

The Council of the Ohio State Medical Association has been advised by the Ohio Department of Public Welfare that physicians may not employ direct billing of patients who are recipients under the Ohio Department of Public Welfare Aid For the Aged program but must employ the assignment method of billing for such patients. The Council has received from the Ohio Department of Public Welfare a copy of its letter dated October 21, 1966 addressed to the physicians of Ohio on the subject of "Billing Procedures — Charges for Services Provided On Hand After July 1, 1966 to Recipients 65 Years of Age and Over," a copy of which letter is attached hereto.

In enacting Public Law 89-97 Congress specifically

provided that physicians may employ either of two methods of billing:

(a) directly billing the patient; or
(b) billing by means of an assignment executed by the patient and accepted by the physician.

Congress also specifically provided in Public Law 89-97 that every patient shall have and enjoy the right of free choice of physician and Congress specifically disclaimed any supervision or control over the practice of medicine or the manner in which medical services are provided or over the administration or operation of any institution, agency or person providing health services.

It is the official policy of this association, as already established by The Council and endorsed by the House of Delegates of this association that all physicians should be encouraged to bill directly all their patients for all medical services rendered to them, regardless of what third parties may be involved.

This association takes strong issue with the following statement in the Department of Public Welfare's letter of October 21, 1966:

"A claim on Form 1490 may only be filed on the basis of a receipted bill or through the acceptance of an assignment by a physician. Since the public assistance **recipients may not be given money for the purpose of paying medical bills directly and can not be reimbursed from welfare funds if they make a payment to the physician,** the assignment method appears to be the only practical way for handling bills for services rendered to welfare recipients."

In this connection attention is called to Ohio Revised Code Section 5105.12 in which it is expressly recited that:

"warrants for the payment of medical, dental, optometrical, nursing, or hospital care, shall be, at the option of the department (Ohio Department of Public Welfare), made payable to, and delivered directly to, either the recipient or persons or agencies furnishing such care."

It is abundantly clear that this Ohio statute permits payment to be made either directly to the welfare recipient or directly to the physician and without the necessity of an assignment in either case.

Every member of this association is urged to bill welfare recipients directly (as is specifically permitted under Public Law 89-97 and under Section 5105.12 of the Ohio Revised Code) and to bill all patients directly in accordance with the established policy of this association. Members of the profession are reminded that any dictation or control by any lay party or organization over the practice of medicine inevitably leads to the deterioration of quality medical care and to the injury of the public. Every member of the profession is accordingly advised to guard zealously his professional freedom, to resist strongly any and all efforts to interfere with or exercise control over his right and duty to practice medicine in accordance with his best medical judgment, to oppose vigorously any attempt to interfere with the personal and confidential relationship of physician and patient or to impair in the least the valuable right of the patient to a free choice of physician. Only by so doing can the profession assure to patients a continuation of the high quality medical care which they now enjoy.

Council Instructions

It was the instruction of The Council that the statement of position dealing with the Ohio Department of Welfare be issued to all members of the Ohio State Medical Association (Medicare Newsletter No. 6) and to county societies, specialty societies, American Medical Association and to other state medical associations.

The Council requested that the statement of position be accompanied by a letter from the President of the Association, explaining the necessity for this action.

The Council further requested that a special letter from the President of the Association be sent to all attending the officers meeting of October 23, 1966, thanking them for their enthusiastic participation in developing the policy of the Association with regard to the matters at hand and explaining recent developments which have required an alteration, so that the statement regarding billing methods is directed toward the Ohio Department of Welfare rather than the U. S. Department of Health, Education, and Welfare. It was requested that a copy of the Ohio Department of Welfare letter, dated October 21, 1966, be attached thereto.

Utilization Review Committees

The Council then adopted the following statement with regard to Utilization Review Committees:

STATEMENT OF POLICY OF THE COUNCIL OF THE OHIO STATE MEDICAL ASSOCIATION REGARDING UTILIZATION REVIEW COMMITTEES OF HOSPITALS AND EXTENDED CARE FACILITIES

The U. S. Department of Health, Education, and Welfare, through its Division of Medical Care Administration, has expressed a specific interest in engaging contracts "to plan for, establish and support the initial operation of community-based utilization review plans for hospitals and extended care facilities."

It is the official policy of this Association that:

(1) The function of a utilization review committee is a purely medical function.

(2) The responsibility and obligation of such committees are medical only.

(3) Every utilization review committee shall be composed solely of practicing physicians.

(4) When such a committee enters into an

agreement or contract with any third party, the fulfillment of its medical responsibility and obligation is seriously jeopardized.

(5) When a utilization review committee or its individual members accept remuneration for carrying out the medical responsibilities of the committee, an employer-employee relationship is established, which leads to lay influence and control over matters which are strictly medical.

(6) Since the function of a utilization review committee is exclusively medical in nature and purpose, its findings and recommendations should be limited to medical decisions and should not include recommendations with respect to third-party benefits to the patient.

(7) This Association recommends to each component County Medical Society that it point out to the utilization review committees in its county the proper function of such committees and the limits of their responsibilities and obligations.

(8) Each County Medical Society is urged to establish, or cause to be established, a utilization review committee. In event a County Medical Society does not have sufficient professional personnel available to establish an effective Utilization Review Committee, such County Society is urged to seek the aid of this Association in establishing an area Utilization Review Committee which would function in two or more counties.

The Council instructed the Executive Secretary to notify Dr. James L. Henry of the acceptance of his statement for information and future consideration, and to convey the thanks of The Council for his assistance.

Additional Actions

A motion to continue with additional docket items was officially adopted.

Direct Billing — AMA Resolution

The following resolution on direct billing (shown here in its final form) was adopted as OSMA policy and approved for submission to the AMA House of Delegates:

WHEREAS, the Principles of Medical Ethics forbid the rendition of a physician's services under terms and conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care, forbid both the payment and the receipt of a commission for the referral of patients, and forbid the solicitation of patients; and

WHEREAS, the American Medical Association has repeatedly denounced as unethical any professional-lay relationship or arrangement which results: (1) in the denial of, or interference with, the free choice of a physician; or (2) in the deterioration of the physician-patient relationship; or (3) in the splitting of fees with a lay organization; or (4) in the accrual to lay employers of a direct profit from the fees paid for professional services; or (5) in the exploitation of the services of the physician for the financial profit or benefit of a lay agency or organization; and

WHEREAS, it is evident that the ethical questions arising from any such relationships or arrangements can be greatly minimized or entirely eliminated through the regular use by every physician of the procedure of direct billing; and

WHEREAS, the House of Delegates of the American Medical Association on October 3, 1965, adopted the following resolution:

"Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists **should not be merged with hospital charges.** The charges for the services of such specialists should be **established, billed, and collected by the medical specialist in the same manner as are the fees of other physicians.** The American Medical Association intends to continue vigorously its efforts to prevent inclusion in the future of the professional services of any practicing physician in the hospital service portion of any health care legislation."

NOW, THEREFORE, BE IT RESOLVED, that the actions of the American Medical Association in denouncing as unethical any professional-lay relationship or arrangement which results: (1) in the denial of, or interference with, the free choice of a physician; or (2) in the deterioration of the physician-patient relationship; or (3) in the splitting of fees with a lay organization; or (4) in the accrual to lay employers of a direct profit from the fees paid for professional services; or (5) in the exploitation of the services of the physician for the financial profit or benefit of a lay agency or organization, be and the same hereby are, approved, confirmed and ratified; and

RESOLVED FURTHER, that the foregoing October 3, 1965 resolution of the House of Delegates be, and it hereby is, reaffirmed and reapproved; and

RESOLVED FURTHER, that the American Medical Association implement the October 3, 1965 resolution by calling to the attention of all physicians, and particularly hospital-based physicians, the desirability of the adoption and use of the direct billing procedure and urging them to employ such procedure in all cases; and

RESOLVED FURTHER, that the term "direct billing" means and is hereby defined as the preparation of a separate bill for professional services on the physician's own letterhead (or billhead), addressed to the patient (or the member of the pa-

tient's family legally responsible for payment of such services), and mailed or delivered to the patient, without any notice to, or understanding with, either the hospital in which the professional services were rendered or the patient that:

(1) the patient has no responsibility for the payment of such bill and may ignore it, or

(2) the patient may relieve himself of his responsibility to the physician for payment by (a) transmitting such bill to the hospital in which the professional services were rendered or (b) transmitting such bill to an organization or carrier which provides coverage to such hospital for hospital services as distinguished from professional services, and

RESOLVED FURTHER, that the foregoing pronouncements concerning unethical professional-lay arrangements and concerning direct billing by hospital-based medical specialists shall apply to every professional-lay arrangement with a hospital, corporation or other lay agency regardless of whether such hospital, corporation or other lay agency is organized and operated as an organization for profit or as a nonprofit organization.

Third Party Problems

Dr. Meredith briefly discussed hospital medical staff disciplinary procedures. It was the consensus that additional attention should be given this matter in a future Medicare Newsletter, and the proper source of information would be the booklet, "Statements of Policy — Third-Party Medical Care Plans."

Direct Billing Information Program

On a motion by Dr. Light, seconded by Dr. Ivins and passed, the staff was authorized to develop a direct billing promotion program along the lines of that being implemented by the Louisiana State Medical Society.

Travel Insurance

By official action, The Council adopted that section of the minutes of the OSMA Insurance Committee session of October 9, which dealt with Travel Accident Insurance. Council voted to accept the three-year policy outlined by the Committee, subject to the consideration and the approval of the general counsel.

There being no further business, The Council adjourned.

ATTEST: HART F. PAGE
Executive Secretary

Minutes of Special Conference of The Council on November 1

A telephone conference of The Council of the Ohio State Medical Association was held at 3 p. m., November 1, 1966. The following members of The Council participated: President Meredith, President-Elect Howard, Past President Crawford and Councilors Ivins, Light, Merchant, Smith, Robechek, Westbrook, Press, Beardsley, Clarke, Fulton and Schultz. Also in the conference was Mr. Hart F. Page, OSMA Executive Secretary.

The purpose of the conference call was the consideration of the following paragraph for addition to the OSMA policy on direct billing which was adopted October 26, 1966:

"RESOLVED FURTHER, that the foregoing pronouncements concerning unethical professional-lay arrangements and concerning direct billing by hospital-based medical specialists shall apply to every professional-lay arrangement with a hospital, corporation, or other lay agency regardless of whether such hospital, corporation, or other lay agency is organized and operated as an organization for profit or as a nonprofit organization."

The Council voted to accept the above paragraph for inclusion in the official policy. (See entire resolution, including this paragraph, on this and preceding pages.

Adjourned.

ATTEST: HART F. PAGE,
Executive Secretary

Keep Narcotic Drugs Safeguarded, Treasury Department Warns

Thefts of narcotic drugs are alarmingly high, according to an announcement by the Treasury Department's Bureau of Narcotics, and all persons registered under the federal narcotics law are warned to take extra precautions in safeguarding their stocks.

During the 12-month period ending December 31, 1965, there were 2,503 thefts of narcotic drugs from persons registered under the narcotics law. This is the largest number of thefts ever reported in a single year, and accounted for a loss of some 292 pounds of drugs.

Section 151.471 of Regulations No. 5 requires that "Narcotic drugs and preparations shall at all times be properly safeguarded and securely kept . . ." Henry L. Giordano, commissioner of narcotics, states that appropriate security measures must be taken depending on the kind and size of stock, the immediate surroundings, and the general circumstances.

Standards for safeguarding narcotics of the various classes are set out in the Bureau of Narcotics Order No. 213, which is available on request. Physicians and other persons registered under the narcotics law are invited to consult the narcotics district supervisors for respective areas when in doubt regarding safeguards or when moving narcotic stocks to new locations.

Dr. John G. Boutselis, Columbus, was speaker for a Religion in Life lecture at the University of Dayton. He discussed family planning, using as his title, "Rhythm, — Past, Present, and Future."

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Here, scientists are exploring the mysteries of the life process and of the aberrations we call disease.

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Moves to Combat Athletic Injuries . . .

Joint Committee Lays Plans for Summer Institute, Regional Conferences; Subject Discussed in News Media Interview

THE Joint Committee on Athletic Injuries of the Ohio State Medical Association and the Ohio High School Athletic Association has taken additional positive action toward reducing injuries among participants in high school sports events.

Following a meeting on November 2, the committee announced plans for the Fourth Postgraduate Institute on Athletic Injuries, and set the date for August 16-17, 1967. Dr. Robert J. Murphy, Columbus physician and team doctor for Ohio State University, was appointed chairman of the program committee. The announced place for the conference is the Fort Hayes Hotel in Columbus.

The following possible program topics were suggested: Rehabilitation exercises, physical facilities, drugs, enzymes, ultra-sound, and other much modalities, athletic injuries in elementary school children, and a consideration of desirable athletic competition for elementary school children.

Additional actions of the committee included recommendations for regional conferences for coaches to be held in the Spring of 1967, and for cooperating in a survey of football injuries sustained by Ohio scholastic football players during the 1967 season.

Each year for several years the Joint Committee has been issuing statements for coaches, players, and parents regarding dangers of heat stroke during the early parts of the football season. This action will be taken again for the coming season.

Recently the committee sponsored a news conference in the headquarters office of the Ohio State Medical Association, at which news media personnel interviewed representatives of the Joint Committee on problems arising out of environmental heat and athletic injuries.

Principals in this interview, all members of the Joint Committee, were Robert J. Murphy, M. D., Columbus, team physician for the Ohio State University; Thomas E. Shaffer, M. D., Columbus, professor of pediatric medicine at Ohio State, and associated with the Center for Adolescents at Children's Hospital in Columbus; Paul Landis, high school athletic commissioner with the Ohio High School Athletic Association; and Harold Meyer, assistant commissioner with OHSAA.

The interview was set up by the staff of the Ohio State Medical Association at the request of the Joint Committee to better inform the public in this field.





This interview on athletic injuries by news media personnel shows Robert J. Murphy, M. D., left, and Paul Landis, Ohio High School Athletic Commissioner, in front of the camera.

In the insert are Harold Meyer, left, assistant commissioner, and Thomas E. Shaffer, M. D., two other principals in the interviews. The news media interviews were held at the OSMA Headquarters.

Institute on Areawide Planning . . .

OSMA Joins With Other Groups Interested in Hospitals And Related Health Facilities for January 15 Program

THE Ohio State Medical Association is one of the sponsors of "An Institute on Areawide Planning for Hospitals and Related Health Facilities," to be held in Columbus on Sunday, January 15. Persons invited to attend are medical staff representatives and administrators of hospitals and related health facilities; members of County Medical Societies and members of Academies of Osteopathic Medicine; trustees, committee members and staff members of areawide health facility planning agencies, hospital membership associations; personnel of Blue Cross, health insurance companies, health and welfare councils; and officials of governmental agencies involved in hospital planning.

Sponsors, in addition to the Ohio State Medical Association, are the Ohio Hospital Association, and the Ohio Osteopathic Association of Physicians and Surgeons.

Purposes of the Institute are to review planning by individual hospitals and related health facilities in response to changing community health needs, specialized service requirements, advances in medical education and research; also to further promote working relationships with voluntary areawide health facility planning agencies.

Meeting place is the Sheraton-Columbus Motor Hotel in downtown Columbus. Time is 9:30 A. M. to 3:30 P. M.

The program has been announced as follows:

Morning Session

Presiding: Wilson L. Benfer, chairman, OHA Coordinating Committee for Health Facility Planning.

Responding to Changing Community Health Needs — Robert Craig, M. D., chairman, Committee on Hospital Relations, OSMA.

Responding to New Demands for Specialized Services and Facilities: — Extended Care Services — Mrs. Helen D. McQuire, director, Division of Long Term Care, American Hospital Association.

Community Mental Health Programs: "Changing Concepts in Treatment of Mental Health" — Wendell A. Butcher, M. D., chairman of the Committee on Mental Health of OSMA; "Development of Community Mental Health Centers" — George T. Harding, Jr., M. D., legislative chairman, Ohio Psychiatric Association.

Professional Health Personnel Requirements — William G. Pace, M. D., assistant dean, Ohio State University College of Medicine.

Afternoon Session

Presiding: William R. Schultz, M. D., vice-chairman, OHA Coordinating Committee for Health Facility Planning.

Responding to Advances in Medical Research and Education — Clifford G. Grulee, Jr., M. D., dean, University of Cincinnati College of Medicine.

Meeting Planning Responsibilities — Hospital Planning Association of Greater Toledo.

PROGRAM: Institute on Areawide Planning for Hospitals and Related Health Facilities
PLACE: Sheraton-Columbus Motor Hotel, Third and Gay Streets, Columbus
TIME: 9:30 A. M. — 3:30 P. M. — January 15, 1967
FEE: $6.00 per person (Includes Lunch)

Registrant's Name .....
(If more than one person, please list other)

Title .....

Address .....

Mail to:
Ohio Hospital Association
Room 501, 40 South Third St.
Columbus, Ohio 43215

Make Checks payable to the Ohio Hospital Association

Receipt of your application will be acknowledged, and a blank sent to you, should you desire to make hotel reservations. The telephone number at the Sheraton-Columbus Hotel is 228-6060.

H. M. Platter, OSMA Past President, Medical Board Secretary, Dies

Herbert Morris Platter, M. D., Past President of the Ohio State Medical Association, venerable secretary of the State Medical Board of Ohio, and a former practicing physician in Columbus, died at the age of 97 on November 4.

Numerous honors had been bestowed upon Dr. Platter on the local, state, and national levels for his untiring efforts in behalf of medicine and the public health. At the 1966 OSMA Annual Meeting in Cleveland, the entire program was dedicated in his honor. In memorializing Dr. Platter on this occasion, the OSMA House of Delegates resolved in part "That the Ohio State Medical Association and the physicians of Ohio hereby express their admiration and gratitude to Dr. Platter for his outstanding leadership, guidance, and counsel."

On this same occasion, Lieutenant Governor John W. Brown paid tribute to Dr. Platter for his years of service with the State Medical Board and brought a message of commendation from Governor Rhodes.

In 1964 Dr. Platter was guest of honor at the Annual Convention of the American Medical Association in San Francisco, and was presented a Certificate of Merit for his pioneering service to the AMA. The honor referred back to 1899 and the AMA Convention in Columbus, on which occasion Dr. Platter was instrumental in initiating the first scientific exhibit ever shown at an AMA meeting.

It was in 1964 also that the Executive Committee of the Federation of State Medical Boards presented a citation entitled "The Impact of Herbert Morris Platter, M. D., on American Medicine."

Dr. Platter was born at Lockbourne on June 18, 1869. He attended Ohio Wesleyan University, and received his medical degree from Starling Medical College, Columbus, in 1892. His early interest in medical organization work is shown in the fact that from 1883 to 1899 he was secretary of the Columbus Academy of Medicine. In the latter year he became assistant secretary of the Ohio State Medical Society.

From 1899 to 1908 he was associated with the Columbus Board of Health, in charge of work in contagious diseases in addition to his private practice. From 1908 to 1911 he was epidemiologist for the State Department of Health. It was in 1911 that he went to Europe to study dermatology in Berlin and in Vienna. From that time until 1954 his part-time practice was in the field of dermatology.

From 1912 to 1917 he was chief of the Division of School Health for the Columbus Board of Education, and helped to write the first Columbus public school health code. In 1917 Dr. Platter became secretary of the State Medical Board, a position he held until his retirement on December 31, 1965.

A past president of the Columbus Academy of Medicine, he was treasurer of the Ohio State Medical Association from 1918 to 1931 when he was named President-Elect of the State Association. In 1932 he was installed as President of the Association and served in that office for the term 1932-1933.



Dr. Platter is shown here as he appeared before the AMA House of Delegates at the 1964 Annual Convention in San Francisco.

Dr. Platter was a Past President of the Federation of Licensing Board of the U. S.; a member of the National Board of Medical Examiners and in 1954 completed two terms of six years each as representative.

Teaching was another field for Dr. Platter. From 1929 to 1942 he was on the faculty of the Ohio State University College of Medicine where he lectured in dermatology and medical law.

Dr. Platter was a member of the Presbyterian Church and several Masonic bodies. He is survived by a son, Harold O. Platter of Columbus and Reynoldsburg, by a son-in-law and by a grandchild and great grandchildren.

Eben Leon Brady, M. D., Texas City, Texas; Ohio Medical University, Columbus, 1903; aged 86; died

September 24; member of the Ohio State Medical Association and the American Medical Association. A physician of long standing in Marion, Dr. Brady specialized in the EENT field. He was a past president of the Marion County Medical Society, and a past president and former treasurer of the Northwestern Ohio Medical Association. Honored with the United Community Service Award, he was active in numerous local organizations; he was past president of the Rotary Club, a member of the YMCA board, the Aero Medical Association, the Chamber of Commerce, Catholic Church, Knights of Columbus, Salvation Army board, Moose, Elks, and Eagles Lodges. Survivors include a son and a daughter.

Basil Butheway Brim, M. D., Bradenton, Florida; University of Maryland School of Medicine, 1902; aged 86; died October 18; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in the West Toledo area, Dr. Brim retired several years ago and was making his permanent home in Florida. A veteran of World War I, he was a member of the American Legion. Other affiliations included memberships in the Masonic Lodge and the Elks Lodge. Two daughters and a sister survive.

John Edwin Brown, Sr., M. D., Columbus; Medical College of Ohio, Cincinnati, 1887; aged 102; died November 2; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Otolaryngology, and the American Laryngology, Rhinology and Otology Society; diplomate of the American Board of Ophthalmology and the American Board of Otolaryngology.

Widely recognized for his activity in medical organization work and for his contributions in his specialty field over a practice span of some 55 years, Dr. Brown was honored in absentia at the dinner meeting of the OSMA Section on Otorhinolaryngology in 1964. A plaque was presented in behalf of the Centurion Club of the Deafness Research Foundation. Feature articles on Dr. Brown appeared in several newspapers at the time, especially the *Columbus Dispatch* and the *Columbus Citizen-Journal.*

Also in 1964 on the occasion of Dr. Brown's 100th birthday, the Academy of Medicine of Columbus and Franklin County paid special tribute to him and dedicated an issue of its *Bulletin* in his honor.

Dr. Brown actively practiced medicine from 1888 when he first opened his office in Columbus to 1944. He was the fifth president of the Columbus Academy of Medicine, holding that office in 1896. From 1894 to 1927, he was on the teaching staff of Ohio Medical University and its successors, Starling-Ohio and Ohio State University.

He became president of the American Academy of Ophthalmology and Otolaryngology in 1916. Among his numerous other affiliations, he was president of the Board of Trustees of Ohio Wesleyan University, his Alma Mater.

Dr. Brown is survived by grandchildren. His son, Dr. John Edwin Brown, Jr., was a practicing physician in Columbus before his death in 1958.

Fritz Paul Bucher, M. D., Dayton; University of Cincinnati College of Medicine, 1930; aged 66; died October 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Bucher was a general practitioner in the Dayton area for some 35 years. Among affiliations, he was a member of the Fraternal Order of Police in Oakwood and was a member of the Catholic Church. He is survived by his widow, a daughter, two sons, and three brothers.

Salvador M. Capote, M. D., Columbus and Whitehall; graduate of the Faculty of Medicine of the University of Havana; aged 64; died October 22. A former practicing physician in Cuba, Dr. Capote fled that country in 1962 and was making his home with a daughter in Whitehall, while on the staff of the Alum Crest Hospital in Columbus. Other survivors are a son in Cuba, a brother and six sisters.

Ferdinand Donath, M. D., Cincinnati; University of Vienna Faculty of Medicine, 1921; aged 71; died October 4; member of the Ohio State Medical Association, the American Medical Association, American Psychosomatic Society, and the American College of Cardiology. A former practitioner in Austria before he came to this country, Dr. Donath had been in Cincinnati since 1939. His specialty was cardiology and he was associate clinical professor in the University of Cincinnati College of Medicine. Survivors include his widow, a daughter, and a son, Dr. Rudolf Donath, Cincinnati; also a sister, Dr. Hedwig Lang, of Columbus, and a brother.

Joseph W. Epstein, M. D., Cleveland; Western Reserve University School of Medicine, 1911; aged 80; died October 2; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A native of Lithuania, Dr. Epstein entered medical school in Cleveland in 1907, pioneered in pediatrics, and became chief of pediatrics when Mount Sinai Hospital opened. A member of the board at Park Synagogue, he is survived by his widow and three sons, among them, Dr. Harold Epstein, of Cleveland, and Dr. Lloyd Epstein, of Tucson, Arizona.

Robert Russell Hollister, M. D., Yellow Springs; Harvard Medical School, 1902; aged 93; died September 7. A practitioner in Omaha, Nebraska, for some 40 years, Dr. Hollister moved to Yellow

Springs in 1947. Dr. Nathaniel R. Hollister, of Dayton, is one of three sons who survive. His widow and a daughter are also among survivors.

Edward Thomas Hurley, M. D., Fort Lauderdale, Florida; Stritch School of Medicine of Loyola University, 1916; aged 85; died October 13; former member of the Ohio State Medical Association. Dr. Hurley practiced for many years in Conneaut, and in Cleveland's West Side before he retired in 1959 and moved to Florida. He was a veteran of World War I. Surviving are his widow, a son, and a daughter.

Virgil E. Hutchens, M. D., Wilmington; Eclectic Medical College, Cincinnati, 1911; aged 84; died September 30; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Clinton County, Dr. Hutchens was active in numerous civic activities. He was a member of the Rotary Club, the Masonic Lodge, Methodist Church, and the Odd Fellows Lodge. Among survivors are his widow and a son.

William Wolfgang Klement, M. D., Cincinnati, Eclectic Medical College, Cincinnati, 1917; aged 76; died October 8; member of the Ohio State Medical Association, the American Medical Association, and American Academy of General Practice; Fellow of the American College of Physicians. A practitioner in Cincinnati for many years, Dr. Klement was a member of the Association of Military Surgeons. Among other affiliations, he was a member of several Masonic bodies.

George Louis Lambright, Ormond Beach, Florida; Ohio State University College of Medicine, 1913; aged 77; died October 22; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. A former practitioner in Cleveland, Dr. Lambright specialized in internal medicine and allergy. He retired in 1954 and was making his home in Florida. His widow and a daughter survive.

Amore Longano, M. D., Cleveland; Faculty of Medicine of the University of Rome, Italy, 1946; aged 50; died August 17; former member of the Ohio State Medical Association and the American Medical Association. Dr. Longano was engaged in the general practice of medicine in Cleveland. He was married and the father of two children.

George Jacob Mateja, M. D., Cleveland; Ohio State University College of Medicine, 1918; aged 75; died October 2; former member of the Ohio State Medical Association. A practitioner of long standing in Cleveland, Dr. Mateja was a veteran of World War I and a member of the American Legion. Other affiliations included membership in the Masonic Lodge. His widow and a son survive.

Thomas Carolus G. Matolcsy, M. D., Cleveland; Medical Faculty of the University of Budapest, 1924; aged 65; died October 20. Dr. Matolcsy was educated in Europe and practiced there before he came to this country in 1957. His practice in Cleveland was in the field of surgery. Survivors include his widow, a son, and four daughters.

Ethel Doris Pillion, M. D., Lorain; State University of New York at Buffalo School of Medicine, 1924; aged 63; died October 1; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Pillion devoted virtually all of her professional career to practice in the Lorain area.

Harry Walter Reed, M. D., Lathrup Village, Mich.; Western Reserve University School of Medicine, 1911; aged 76; died June 28. Dr. Reed left Ohio many years ago to practice in Detroit.

Harry Frank Schneider, M. D., Mount Washington; University of Cincinnati College of Medicine, 1954; aged 40; died October 1; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A lifelong resident of Mount Washington, Dr. Schneider set up his practice in that part of the Greater Cincinnati area when he completed his medical training. He is survived by his widow, his parents, and a brother.

Frederick Henry Stires, M. D., Canton; Ohio State University College of Medicine, 1921; aged 71; died October 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Stires began his practice in Malvern, in Carroll County. He later took residency training in Akron and opened his practice for surgery in Canton. Retirement was in 1954. Two physician members of the family are a son, Dr. William J. Stires, of Canton, and a brother, Dr. Joseph Stires, of Malvern. Other survivors are his widow, a daughter, a second son, a sister and another brother.

Paul Windom Sutton, M. D., Cincinnati; Johns Hopkins University School of Medicine, 1921; aged 72; died October 7; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. A practitioner in the field of surgery for many years in Cincinnati, Dr. Sutton was associate clinical professor of surgery in the University of Cincinnati Col-

lege of Medicine. Among survivors are his widow, two sons, three sisters, and three brothers.

Helen Burton Todd, M. D., Meriden, Conn.; Boston University School of Medicine, 1914; aged 79; died August 29; former member of the Ohio State Medical Association. Dr. Todd moved to Connecticut in 1949 after a long career at Bowling Green, where she was associated with the medical center of the Bowling Green State University.

Walter Charles Vester, M. D., Cincinnati; University of Cincinnati College of Medicine, 1922; aged 71; died October 14; member of the Ohio State Medical Association, the American Medical Association, and the American College of Cardiology. A native of Cincinnati, Dr. Vester devoted a lifetime to practice there, specializing in cardiology. Surviving are a daughter and three sons, one of whom is Dr. John W. Vester, of Pittsburgh, Pa.

Homer H. Williams, M. D., Dayton; Ohio State University College of Medicine, 1917; aged 75; died October 19; member of the Ohio State Medical Association and the American Medical Association. A career health officer, Dr. Williams began his service with the Dayton Health Department in 1923 as bacteriologist, and was appointed health commissioner in 1937. He was at his office in the Dayton Municipal Building when fatally stricken. His widow survives.

Health Insurance Protection Widespread in America

Twenty-six states have at least 75 per cent of their civilian populations protected by some form of private health insurance, the Health Insurance Institute reported.

At the beginning of 1966, another 23 states had between 50 and 75 per cent population coverage.

Alaska, said the Institute, was the only state below the 50 per cent mark (44 per cent).

The nation as a whole had 81 per cent of the civilian population protected under some form of private health insurance provided by insurance companies, Blue Cross, Blue Shield, and other health care expense plans.

The Institute said its report was based on the Health Insurance Council's 20th Annual Survey on the Extent of voluntary health insurance in the United States in 1965. Survey data was compiled according to place of employment.

Insurance companies, government agencies and published Blue Cross, Blue Shield reports, were sources for the Council's statistics.

In a breakdown of percentage coverage by regions, the East North Central States, including Ohio, showed an 89 per cent population protection, second only to the Middle Atlantic States with 91 per cent.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during October. List shows name of physician, county, and city in which he is practicing, or temporary addresses for those taking graduate work:

Ashtabula
Arthur P. Holstein, Ashtabula

Butler
Frederick S. Cieslak, Hamilton
Albert S. Palatchi, Hamilton
Agustin R. Rodriguez, Middletown
Ramon D. Turman, Hamilton

Clark
Dale E. French, Springfield
Garner M. Robertson, Springfield
Thomas J. Williams, Springfield

Clinton
Paul William Terrell, New Vienna

Columbiana
Benjamin S. Francisco, Salem

Cuyahoga
David A. Conant, Cleveland
William B. Lasersohn, Cleveland
Morris J. Mandel, Cleveland
Frederick P. Meyerhoefer, Cleveland
Klaus H. Neumann, Cleveland
Baba G. Pawar, Cleveland
Charles B. Payne, Cleveland
Abbas Rejali, Cleveland
Martin W. Sklaire, Cleveland
Timothy L. Stephens, Jr., Cleveland
Ivan Tewarson, Cleveland
Charles R. Young, Cleveland

Franklin
Robert B. Hewitt, Columbus
Martin A. Torch, Abilene, Texas

Greene
Edward P. Call, Yellow Springs
Jose R. Ensenat, Fairborn

Hamilton
Alvin A. Huesman, Cincinnati
James Bennett Kahl, Cincinnati
Ralph D. Parks, Cincinnati
M. Richard Schorr, Cincinnati
Frederick W. Wiese, Cincinnati
Ben T. Yamaguchi, Jr., Cincinnati

Jefferson
Fernando T. Rivera, Jr., Steubenville
Francis A. Sunseri, Steubenville

Knox
Emerson L. Laird, Mt. Vernon
Robert L. Westerheide, Mt. Vernon

Lorain
Mohammed A. Amiri, Lorain
George P. Gotsis, Lorain
Lawrence G. Thorley, Amherst
Charles E. Zepp, Elyria

Ross
Jechiel M. Friedmann, Chillicothe

Summit
Constantine Mourat, Akron

National Rural Health Conference Scheduled in Charlotte, N. C.

The 20th National Conference on Rural Health, sponsored by the American Medical Association Council on Rural Health, will be held on Friday and Saturday, March 10 and 11, at the Queen Charlotte Hotel, Charlotte, North Carolina.

With the theme "Rural-Urban Health Relationships," the purpose will be to explore new needs and report on developments in the following fields: Community planning and responsibility for health facilities and services; future patterns of personal health care; rural accident prevention and first aid instructions; health manpower planning and utilizing.

Dr. Julius Nemeth, director of the Community Services Unit of Woodside Receiving Hospital, Youngstown, was elected president of the Association of Physicians of the Ohio Department of Mental Hygiene and Correction at the recent convention in Columbus.

Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.



Regroton®

chlorthalidone 50 mg. reserpine 0.25 mg.

1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

Activities of County Societies . . .

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

HAMILTON

For the November 15 meeting of the Academy of Medicine of Cincinnati, the program consisted of a panel discussion on the topic, "Governmental Medicine Here and Abroad."

Panelists were Dr. Edward W. Parry, consultant surgeon to Liverpool Regional Hospital Board, and lecturer in clinical surgery, Medical School, University of Liverpool, England; and Dr. Philip R. Lee, assistant secretary, Department of Health, Education, and Scientific Affairs, Washington, D. C.

Moderator of the panel was Dr. Frank P. Cleveland, associate professor of forensic pathology, University of Cincinnati College of Medicine.

In addition to activities of the Academy of Medicine, a number of specialty groups are centered in and around Hamilton County and hold regular meetings and scientific programs. The following group meetings during October and early November were announced:

October 5 — Cincinnati Surgical Society.

October 15 — Cincinnati Medical Association.

October 16 — Southwestern Ohio Society of Family Physicians.

October 19 — Cincinnati Society of Neurology and Psychiatry.

October 20-22 — Ohio Valley Proctologic Society.

October 20 — Cincinnati Obstetrical and Gynecological Society.

October 24 — Cincinnati Otolaryngological Society.

November 2 — Cincinnati Dermatological Society.

The Academy of Medicine of Cincinnati had as guest speaker at its October 18 meeting U. S. House Leader Gerald R. Ford, of Michigan, who discussed the outlook in Congress particularly as it pertains to Medicare and similar legislation.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

CLARK

Dr. Clark D. West, Children's Hospital Research Foundation, Cincinnati, was guest speaker for the October 17 meeting of the Clark County Medical Society in Springfield. His topic was "Urinary Tract Infections in Childhood."

DARKE

The Darke County Medical Society and the Wayne Hospital staff recently announced plans for affiliation with the Community Blood Center in Dayton. The plan calls for a countywide blood donor program sponsored by the Medical Society, the supply to be channeled through the Dayton area center.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Dr. John P. Minton, Columbus, was principal speaker for the October 18 dinner meeting of the Academy of Medicine of Lima and Allen County. This topic, "My Experience with the Laser Beam," described the research being carried on at Ohio State University College of Medicine in the field of laser application in the treatment of cancer.

CRAWFORD

The Crawford County Medical Society met in mid-September at the Galion Country Club, Galion, for a dinner and program.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The Bulletin of the Academy of Medicine of Toledo and Lucas County listed among other meetings in the Toledo area the following:

November 10-11 — Postgraduate Lecture Series presented by the Medical Advancement Trust of Maumee Valley Hospital. Guest speaker was Dr. Sydney Gellis, chief of pediatrics, Tufts-New England Medical Center, Boston, who spoke on various phases of pediatrics.

November 18 — Seminar on Marriage Counseling, sponsored by the Toledo Obstetrical and Gynecological Society, held at the Academy Building. Guest speaker was Richard H. Klemer, Ph. D., associate professor of family relations, University of Washington, Seattle.

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

CUYAHOGA

A medicine and religion meeting of the Academy of Medicine of Cleveland was held on the evening of October 19. The theme, "Facing the Nameless

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Fear," dealt with the proposition of the individual's struggle for personal meaning in a world of anonymity.

Among speakers on the panel discussion were Robert O. Blood, Jr., Ph. D., Robert H. Bonthius, Ph. D., and Arthur D. Weatherhead, M. D. Executive Secretary Robert A. Lang was moderator.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

Dr. Edward R. Annis addressed the Mahoning County Medical Society by special telephone hook-up from South Bend, Indiana, at the regular society meeting, October 18. Guests at the meeting were Dr. Lawrence C. Meredith, OSMA President, and Dr. Edwin R. Westbrook, Sixth District Councilor.

Dr. Annis spoke on the general subject of "Organized Medicine at the Crossroads," and took extra time to answer questions from members attending the meeting.

He accused HEW of violating the medicare law by writing regulations contrary to the intent of the law. He warned against signing special forms of certification of hospitalization as an initial step which might lead to further restrictions on doctors, such as loss of the right to prescribe name drugs to medicare patients, and mandatory acceptance of assignments.

He urged all physicians to obey the medicare law, but to resist governmental interference that threatens patient care.

Dr. Jack Schreiber, program chairman, moderated the telephone conversation, which was heard by the audience over the loud-speakers. Dr. Harold J. Reese, president-elect, presided.

Seventh District

(COUNCILOR: SANFORD PRESS, M. D., STEUBENVILLE)

BELMONT

The Belmont County Medical Society with the Auxiliary met at the Belmont Hills Country Club on October 20 for an afternoon business session and dinner.

Highlight of the meeting was presentation of the Ohio State Medical Association 50-Year Award to Dr. Frederick P. Sutherland, physician of long standing in the Martins Ferry area. Dr. Sanford Press, Steubenville, Councilor of the Seventh District, made the presentation.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, WOOSTER)

LORAIN

Recognition of two area physicians, signifying their graduation from Medical School 50 years ago, was a feature of the regular meeting of Lorain County Medical Society during the November 8 meeting at Oberlin Inn.

The Pins and Certificates of Distinction conferred by Ohio State Medical Association, were presented by William R. Schultz, M. D., of Wooster, Councilor of the Eleventh District, to Frank A. Lawrence, M. D., of Elyria, and John H. Nichols, M. D., of Oberlin. Preceding the presentations, James T. Stephens, M. D., of Oberlin, outlined the achievements of Dr. Nichols, and Joseph M. Strong, M. D., of Elyria, recalled the contributions of Dr. Lawrence in service to his community over the years. Dr. John B. McCoy accepted on behalf of Dr. Lawrence who spends the winter months in Florida.

A Cleveland physician, Randall H. Travis, M. D., presented the evening's program on the topic "Physiological Aspects of Diuretic Therapy," illustrating his lecture with slide presentations. This interesting program was sponsored by the Medical Services Department of G. D. Searle & Company, of Chicago, arranged with their local representative, William L. Perkins, of Bay Village, under the Searle Company's Postgraduate Education Program.

Dr. Travis is assistant professor in the Department of Physiology, Western Reserve University School of Medicine, Cleveland, and a member of the American Association for the Advancement of Science.

During the business meeting, Dr. John W. Wherry, chairman of the Nominating Committee, presented the slate of officers for 1967.

A project of the Education Committee, during Community Health Week in October, was the presentation to High Schools in Lorain County of copies of the American Medical Association's publication *Horizons Unlimited.* These were forwarded for use by the Career Counselors and in the Library of each High School as guidance material for students seriously interested in medicine and health-related fields as a career.

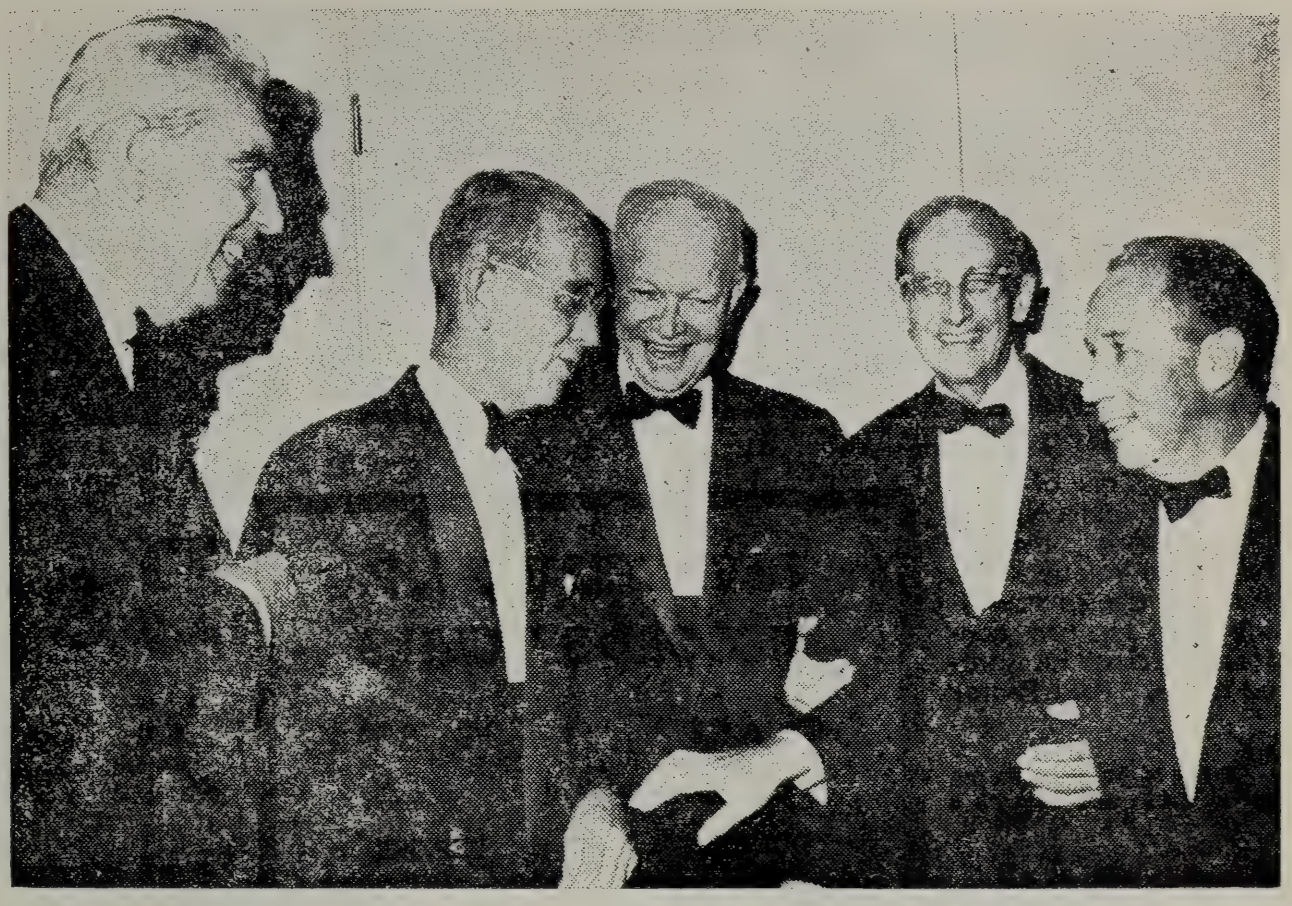
RICHLAND

Members of the Richland County Medical Society participated in a public demonstration and workshop for personnel in use of a packaged disaster hospital unit. The program was in cooperation with the Mansfield General Hospital.

Visiting speaker was Dr. Max Klinghoffer, chairman of the medical disaster care committee in Illinois. Dr. Harry Wain, Mansfield-Richland County health commissioner, took a leading role, as did persons from the Ohio Department of Health.

Dr. Frank P. Cleveland, Hamilton County coroner, was speaker for a dinner meeting of the Southwestern Ohio Association of Industrial Nurses, where he spoke on the topic "Forensic Medicine."

Dignitaries at Cleveland Award Dinner



— Photo Courtesy *The Cleveland Press*

Shown at the Stouffer Prize dinner meeting in Cleveland, from left, are Dr. Ernst Klenk, one of the prize winners; Dr. Irvine H. Page, chairman of the selection committee; Former President Dwight D. Eisenhower; Dr. Harry Goldblatt, Cleveland prize winner; and Vernon Stouffer, founder of the award.

Impressive Ceremonies Mark First Of Stouffer Annual Awards

Nearly 700 persons attended the dinner meeting for presentation of the first annual Stouffer Prize for outstanding contributions in the fight against hypertension.

Among persons who spoke for the occasion were Former President Dwight D. Eisenhower; Sir George Pickering, Regius professor of medicine, Oxford University, England; Dr. Edward H. Ahrens, Jr., Rockefeller University, New York; Dr. Irvine H. Page, Cleveland, chairman of the committee to select award winners; and Cleveland Mayor Ralph Locher.

Vernon Stouffer, head of a chain of restaurants and motor hotels, is founder of the prize award which carries a $50,000 prize as well as citation. This occasion marked the initial presentation of the annual award.

The award was shared by Cleveland's Dr. Harry Goldblatt, emeritus professor of experimental pathology at Western Reserve University School of Medicine and director of the Louis D. Beaumont Memorial Research Laboratories, Mount Sinai Hospital; and Dr. Ernst Klenk, of Cologne, Germany, who has been called the father of modern lipid chemistry.

Fort Steuben Academy

The Fort Steuben Academy of Medicine had as speaker for its November 8 meeting Dr. John Moossy, Pittsburgh, Pa., whose subject was "Cerebrovascular Disease: Necropsy Studies and Clinical Implications." The dinner meeting was held in the Fort Steuben Hotel in Steubenville.

For its October 11 meeting, the Academy had as speaker Dr. Peritz Scheinberg, of Miami, Florida, professor and chairman of the Department of Neurology, Jackson Memorial Hospital, who discussed cerebral vascular disease.

Dr. James Q. Dorgan, Columbus, was among a group of physicians who left this country late in September for a two-months tour of volunteer service in South Vietnam. The physicians are serving in civilian provincial hospitals under the AMA Volunteer Physicians for Vietnam Program.

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Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

CHRISTMAS is synonomous with giving. It brings into focus all that is good in man — his thought for others — his willingness to share — his desire to help. Perhaps to no one time of the year does the project of International Health belong more than to this holiday season. It ties in with the Christmas observance in a very special, very touching way.

To quote Mrs. Max T. Schnitker, state chairman, "in this rapidly shrinking, ever interdependent world, the word 'neighbor' must have a broader interpretation . . . the poor, medically, be it in Viet Nam or South America or anywhere else, are also our concern . . . pain and suffering have no regard for race, creed, color, or geographic location." Isn't that an integral part of "Peace on Earth, Good Will Toward Man"? — something to be practiced not only at Christmas, but the whole year long?

I like to think of Enid Schnitker as the Auxiliary's day-in-and-day-out Santa. Assuredly she's the most attractive Santa around and she has many, many helpers throughout the state. Enid has sparked Project Hope and World Medical Relief into an outstanding activity of Ohio's doctors' wives, with the blessing and help of Mrs. James N. Wychgel, state president.

What better gift could each county auxiliary give this Christmas of 1966 than an organizational membership in Project Hope? It doesn't have to involve a large sum of money (welcome, of course, as that would be). Ruth Wychgel urges that every local group be such an organizational member this year. Your reporter thinks that this is the ideal time to go about being just that! Did you know that it costs five million dollars a year to "run" Hope? The doctors are flown to the ship on a rotating basis and serve without pay. The nurses, technicians, physical therapists, etc., are paid, but far less than they would make in the same job in the United States, and they sign on for a year. For all the other days looming ahead this Auxiliary year, play up Hope in your communities; show Hope films to other groups; sponsor talks on this unique ship; publicize Hope as you have never before done.

Remember World Medical Relief as another project belonging in a sense to the Christmas season, but belonging equally to every day of the year. While the Christmas spirit is in the air, consider this relief project a worth while candidate for special gifts. In a little over a year, that organization has shipped $3.6 million in drugs, supplies, and equipment to medical civilian action teams working among the ill and destitute civilians of Viet Nam. Only as our medical community keeps World Medical Relief supplied, will it be possible to continue sending desperately needed items to the doctors working so unselfishly, not only in Viet Nam but all over the world.

This past auxiliary year, Ohio groups (35 of them) gave 458 cartons, 21 barrels, and 1,564 pounds of drugs. There is no uniformity in the way local auxiliaries send in their reports, hence the "carton," "barrel," and "pound" designations. There was a large variety of equipment that ran the gamut from sterilizers to operating tables. Mrs. Schnitker suggests that in packaging drugs and supplies, local groups use substantial cardboard cartons (such as those originally containing canned soups), or fiberboard drums in which restaurants receive their supplies. The offices of World Medical Relief are at 11745 Twelfth Street, Detroit, Michigan, 48206.

I asked what supplies were the most needed and the answer was **almost** anything in usable condition. There are these exceptions: No basal metabolism machines, no old diathermy, no double beds or mattresses, no heat lamps unless recent models, no ancient electric-treatment apparatus, no clothing except baby shirts and diapers, no electrocardiographs, no fluoroscopes, no medical books or journals, no old therapy machines, no x-ray machines over 5 years old and not under 200 AMP. There is a mimeographed list available, detailing items needed as well as those not considered useable, which Mrs. Schnitker will be glad to send to any local International Health chairman requesting it (although it is my understanding that each such chairman should have received that list recently). Get with it, "girls"! (Well, aren't we!!)

Edna Mae Castle

The Navy League of Cincinnati, an all-male organization, presented citations recently at a luncheon meeting to two women for exceptional patriotic achievements. One of the two is a doctor's widow and Hamilton County auxiliary member, Mrs. Gerald H. Castle, who has served as volunteer educational chairman for Navy groups in the Cincinnati area for more than 20 years. No less a personage than Lieutenant General James Masters, commandant of the Marine Corps School at Quantico, Virginia, presented the awards. Your reporter does not usually play up in this column "extra-curricular" activities of

Medicine Gains Valuable Ground In 1966 General Election

Friends of medicine won telling victories in the 1966 General Election under the banners of both political parties, and many candidates whose actions have produced a threat to the quality of medical care of the American people have been defeated.

One of the outstanding tributes to the activities of of the Ohio profession and families appeared in the October 25 issue of *The Wall Street Journal*. Philip M. Boffey, writer of the article, toured Ohio and wrote an eye-witness account of activities underway at that time.

He told of the independent efforts of Dr. Robert S. Young, of Johnstown, who organized doctors in the campaign which re-elected John M. Ashbrook to Congress from the re-districted 17th District. He also discussed the efforts of the doctors in the campaign which resulted in election of Charles W. Whalen, Jr., to Congress in the Dayton area, and Robert A. Taft, Jr., in Cincinnati.

Mr. Boffey related efforts of Ohio medical groups, primarily the Woman's Auxiliaries in conducting registration and get-out-the-vote drives. He noted that such efforts in the Cincinnati area brought about a registration of about 96 per cent of members of the Academy and their wives, and some 95 per cent in the Dayton area.

Political experts predict that 47 seats picked up by the Republican Party in the U. S. House of Representatives will prompt the 90th Congress to put the brakes on the wild spending spree of the 89th Congress. This prediction is especially true since many analysts name excessive federal spending as a telling issue of the campaign. Sweeping victories and trends of the election will give conservatives of both political parties opportunity to make their voting records count.

Of the Republican gains in the U. S. House, 21 were from the Midwest, with five each from Ohio and Michigan, and four from Iowa. Ohio now has 19 Republican and five Democratic Congressmen. This will be the largest GOP state delegation in the 90th Congress.

In campaigns for the Ohio General Assembly, victories were even more telling. An early start in the campaigns by physicians and their wives paid off with friends of medicine from both parties winning sweeping victories. The political line-up in the 107th Ohio General Assembly, convening January 2, will be, in the House 62 Republicans and 37 Democrats; in the Senate 23 Republicans and 10 Democrats. Again the alignment is weighed heavily in favor of friends of conservative medical and health legislation from both parties.

The Ohio State Medical Association Pre-Election District Conferences during September were well attended by physicians and wives. These conferences did much to unite efforts at the grass-roots level.

The Ohio Medical Political Action Committee had its first big year. Watch for the next issue of *The Journal* and summary of the score chalked up by OMPAC. OMPAC is already building for the 1968 campaign.

Dr. William G. Pace, III, will direct a three-year study in effectiveness of cryogenic surgery on malignant tumors at Ohio State University College of Medicine, under a $100,000 grant from the John A. Hartford Foundation. A phase of the study will be to determine what kinds of tumors respond and degree of the ultra freezing technique most effective.

The American Association of Medical Assistants at its convention in St. Louis named Mrs. Margaret Swank, of Newark, Ohio, as president-elect. She will be installed as president at next year's convention.



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Committee on School Health—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Thomas E. Wilson, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Homer B. Thomas, Gallipolis.

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OSMA Members of the Joint Advisory Committee on Athletic Injuries—Walter A. Hoyt, Jr., Akron; John R. Jones, Toledo; Don A. Kelly, Cleveland; Sol Maggied, West Jefferson; Marvin R. McClellan, Cincinnati; Robert P. McFarland, Oberlin; Charles H. McMullen, Loudonville; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Thomas E. Shaffer, Columbus.

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Ohio Medical Indemnity Liaison Committee — Robert E. Tschantz, Canton, Chairman; Henry A. Crawford, Cleveland; Lawrence C. Meredith, Elyria; Mr. Hart F. Page, Executive Secretary, OSMA, Columbus.

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High Street

ADAMS—Gary J. Greenlee, President, Manchester 45144; Stanley H. Title, Secretary, Manchester 45144.

BROWN—Charles H. Maly, President, Sardinia 45171; Charles W. Hannah, Secretary, Sardinia 45171. 1st Monday monthly.

BUTLER—Robert Johnson, President, 500 S. Breiel Boulevard, Middletown 45042; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 4th Wednesday monthly.

CLERMONT—Cecil F. Barber, President, State Route 133, Felicity 45120; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond 45157. 3rd Wednesday monthly, except July and August.

CLINTON—Richard R. Buchanan, President, 115 West Main, Wilmington 45177; Mary Ranz Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Elmer R. Maurer, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Monthly meeting dates, 1st Tuesday; Academy, 3rd Tuesday, except June, July and August.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Walter Felson, Secretary, 357 South St., Greenfield 45123. 3rd Tuesday bimonthly.

WARREN—O. William Hoffman, President, 20 East Fourth Street, Franklin 45005; Ray E. Simendinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: Theodore L. Light, Dayton 45406
2670 Salem Ave.

CHAMPAIGN—Myron J. Towle, President, 848 Scioto Street, Urbana 43078; Fred R. Denkewalter, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—Henry M. Tardif, President, 2608 E. High Street, Springfield 45505; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 N. Limestone St., Springfield 44503. 3rd Monday monthly, except June, July and August.

DARKE—William A. Browne, President, 722 Sweitzer St., Greenville 45331; Delbert D. Blickenstaff, Secretary, 552 S. West St., Versailles 45380. 3rd Tuesday monthly.

GREENE—Clement G. Austria, President, 1142 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly except July and August.

MIAMI—David Brown, President, 1060 North Market Street, Troy 45373; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua 45356. 1st Tuesday monthly.

MONTGOMERY—Charles E. O'Brien, President, 600 Fidelity Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly October through May — 1st Wednesday June.

PREBLE—John D. Darrow, President, 228 N. Barron St., Eaton 45320; Willard C. Clark, Jr., Secretary, 228 N. Barron, Eaton 45320. Irregular meetings.

SHELBY—George J. Schroer, President, 322 Second Ave., Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney 45365.

Third District

Councilor: Frederick T. Merchant, Marion 43305
1051 Harding Memorial Pky.

ALLEN—Carl H. Zinsmeister, President, 729 W. Market Street, Lima 45801; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly.

AUGLAIZE—Robert Sobocinski, President, 75 Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring Street, St. Marys 45885. 1st Thursday monthly except July.

CRAWFORD—Don E. Ingham, President, 201 N. Market Street, Galion 44833; Johnson H. Chow, Secretary, 1040 Devonwood Drive, Galion 44833. Called meetings.

HANCOCK—Raymond J. Tille, President, 801 S. Main St., Findlay 45840; Herbert L. Queen, Secretary, 828 Woodworth Dr., Findlay 45840.

HARDIN—William D. Dewar, President, 405 North Main Street, Kenton 43326; John J. Roget, Secretary, Belle Center 43310. 2nd Tuesday monthly.

LOGAN—Thomas Seitz, President, 223 E. Columbus Street, Bellefontaine 43311; Glen Miller, Secretary, R. D. 2, West Liberty 43357. 1st Friday monthly.

MARION—Ransome Williams, President, 1035 Harding Memorial Parkway, Marion 43302; Alice Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—R. Duane Bradrick, President, Rockford 45882; R. L. Dobbins, Secretary, 5402 State Route 29 East, Celina. 3rd Thursday, monthly.

SENECA—Olgierd C. Garlo, President, 53 Clay Street, Tiffin 44883; Leonard M. Gaydos, Secretary, 233 South Monroe Street, Tiffin 44883. 3rd Tuesday monthly.

VAN WERT—Norman L. Marxen, President, Medical Arts Bldg., Fox Road, Van Wert 45891; W. L. Iler, Secretary, Medical Arts Bldg., Fox Road, Van Wert 45891. 4th Friday monthly.

WYANDOT—Herschel A. Rhodes, President, 777 N. Sandusky Ave., Upper Sandusky 43351; J. J. Browne, Secretary, 777 N. Sandusky Ave., Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—L. F. Berry, Jr., President, 1400 East Second Street, Defiance 43512; Miss Lois Coffin, Executive Secretary, P. O. Box 386, Defiance 43512.

FULTON—B. H. Reed, Jr., President, Delta 43515; R. L. Davis, Secretary, Wauseon 43567. 2nd Tuesday quarterly March, June, September, December.

HENRY—J. J. Harrison, President, 113 East Clinton Street, Napoleon 43545; Gamble S. Hall, Secretary, 834 Strong Street, Napoleon 43545. 1st Tuesday monthly.

LUCAS—E. L. Doermann, President, 2001 Collingwood Blvd., Toledo 43620; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday monthly except July and August.

OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.

PAULDING—Roy R. Miller, President, 220 W. Perry, Paulding 45879; D. Paul Ward, Secretary, Box 416, Oakwood 45873. Meetings called.

PUTNAM—Arthur P. Daniel, President, 144 N. Walnut, Ottawa 45875; Oliver N. Lugibihl, Secretary, Pandora 45877. 1st Tuesday monthly.

SANDUSKY—J. L. Zimmerman, President, Memorial Hospital of Sandusky County, Fremont 43420; Mrs. Patsy J. Askins. Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.

WILLIAMS—John E. Moats, President, Central Drive, Bryan 43506; Neil T. Levenson, Secretary, 907 Noble Drive, Bryan 43506. 2nd Tuesday monthly.

WOOD—Roger A. Peatee, President, 140 S. Prospect Street, Bowling Green 43402; Douglas Hess, Secretary, 920 North Main St., Bowling Green, Ohio 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44106
10525 Carnegie Ave.

ASHTABULA—J. R. Nolan, President, 2736 Lake Avenue, Ashtabula 44004; Richard Millberg, Secretary, 430 West 25th Street, Ashtabula 44004. 2nd Tuesday monthly.

CUYAHOGA—David Fishman, President, Room 404, 10515 Carnegie Avenue, Cleveland 44106; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.

GEAUGA—Bruce F. Andreas, President, 400 Downing Drive, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

LAKE—Robert W. Colopy, President, 89 E. High Street, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening monthly, January, May, March, September and November unless otherwise ordered by Council.

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

COLUMBIANA—Edith S. Gilmore, President, 432 W. 5th St., E. Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Avenue, Salem 44460. 3rd Tuesday monthly.

MAHONING —F. A. Resch, President, Doctors Park, Canfield 44406; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly except July and August.

PORTAGE—David Palmstrom, President, 124 North Prospect Street, Ravenna 44266; William R. Brinker, Secretary, 141 East Main Street, Kent 44240. 3rd Tuesday monthly.

STARK—A. R. Furnas, Jr., President, 420 Lake Avenue, N. E., Massillon 44646; Mr. John H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.

SUMMIT—James G. Roberts, President, 655 West Market Street, Akron 44303; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, 159 South Main Street, Akron 44308. 1st Tuesday monthly.

TRUMBULL—John F. McGreevey, President, 297 Hawthorne Lane N. E., Warren 44484; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth Street

BELMONT—James Sutherland, President, 9 North 4th Street, Martins Ferry 43935; Bertha M. Joseph, Secretary, 100 South 4th Street, Martins Ferry 43935. 3rd Thursday of February, March, April, June, September, October, November and December.

CARROLL—Glen C. Dowell, President, 207 West Main, Carrollton 44615; Thomas J. Atchison, Secretary, 292 East Main, Carrollton 44615. 1st Thursday monthly.

COSHOCTON—Don Warren, President, 600 East Main Street, West Lafayette 43845; Harold Lear, Secretary, 133 South Fourth Street, Coshocton 43812. 2nd Tuesday monthly.

HARRISON—Charles D. Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988, Quarterly.

JEFFERSON—Jacob R. Cohen, President, 341 Market Street, Steubenville 43952; Irving Dreyer, Secretary, Ohio Valley Hospital, Steubenville 43952. 4th Tuesday monthly except December, January, February.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—Robert J. Kuba, President, 319 Grant St., Dennison 44621; Thomas E. Ogden, Secretary, 138 E. Main St., Gnadenhutten. 2nd Thursday monthly.

Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705
2236 Maple Ave.

ATHENS—D. R. Johnson, President, 52 West Washington Street, Nelsonville 45764; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday monthly except July and August.

FAIRFIELD—George W. LeSar, President, 216 Harmon Avenue, Lancaster 43130; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore 43105. 2nd Tuesday monthly.

GUERNSEY—A. C. Smith, President, 1115 Clark Street, Cambridge 43725; Dayle O. Snyder, Secretary, 840 Wheeling Avenue, Cambridge 43725. 1st Tuesday monthly.

LICKING—Carl L. Petersilge, President, 104 Hudson Avenue, Newark 43055; Robert P. Raker, Secretary, 317 N. Granger Street, Granville 43023. 4th Tuesday monthly.

MORGAN—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, Box 199, Malta 43758.

MUSKINGUM—Paul A. Jones, President, 838 Market Street, Zanesville 43701; Myron Powelson, Secretary, 2825 Maple Avenue, Zanesville 43705. 2nd Tuesday monthly.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, 415 Main Street, Caldwell 43724. 1st Tuesday monthly.

PERRY—Charles B. McDougal, President, 319 High St., New Lexington 43764; Michael P. Clouse, Secretary, West Main St., Somerset 43783.

WASHINGTON—Mary L. Whitacre, President, Rt. 6, Marietta 45750; G. E. Huston, Secretary, 328 Fourth St., Marietta 45750. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Quentin Korfhage, President, Gallipolis Clinic, Gallipolis 45631; John Groth, Secretary, Holzer Clinic, Gallipolis 45631. Monthly meetings at called times.

HOCKING—Jan S. Matthews, President, 9 East Second Street, Logan 43138; H. M. Boocks, Secretary, Route 3, Logan 43138. 2nd Tuesday monthly.

JACKSON—John M. Cook, President, Box 316, Oak Hill 45656; Earl J. Levine, Secretary, 120 N. Ohio Ave., Wellston 45692.

LAWRENCE—Frank W. Crowe, President, 2110 South 9th Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly at called times.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy 45769; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy 45769.

PIKE—Robert T. Leever, President, 100 East Third St., Waverly 45690; Albert M. Shrader, Secretary, East Water St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Erich Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. 2nd Monday in February, April and October; December meeting and summer meeting decided by the Council and members notified one month in advance.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: Richard L. Fulton, Columbus 43212
1211 Dublin Rd.

DELAWARE—Don K. Michel, President, 98 W. William, Delaware 43015; Tennyson Williams, Secretary, Box 265, Delaware 43015. 3rd Tuesday monthly.

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FRANKLIN—Joseph A. Bonta, President, 3100 Olentangy River Road, Columbus 43202; Mr. W. "Bill" Webb, Jr., Executive Secretary, 17 South High St., Suite 528, Columbus 43215. 3rd Tuesday monthly.

KNOX—Richard L. Smythe, President, 812 Coshocton Road, Mt. Vernon 43050; Robert E. Sooy, Secretary, Box 470, Mt. Vernon 43050. 1st Wednesday evening monthly.

MADISON—Sol Maggied, President, 15 East Pearl Street, West Jefferson 43162; Michael Meftah, Secretary, 11 East 2nd Street, London 43140. 1st Wednesday monthly.

MORROW—Francis W. Kubb, President, 140 North Main, Mt. Gilead 43338; William S. Deffinger, Secretary, Box 8, Marengo 43334. 1st Tuesday monthly.

PICKAWAY—V. D. Kerns, President, 143 E. Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney Street, Circleville 43113. 1st Friday evening monthly, except months of July and August.

ROSS—Joseph McKell, President, 174 W. Main Street, Chillicothe 45601; Lowell O. Smith, Secretary, 217 Delano Avenue, Chillicothe 45602. 1st Thursday evening monthly.

UNION—Malcolm MacIvor, President, 110 N. Court St., Marysville 43040; May B. Zaugg, Secretary, 225 Stockdale Drive, Marysville 43040. 1st Tuesday, February, April, October, December.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Road

ASHLAND—Henry C. Chalfant, President, 309 Arthur Street, Ashland 44805; H. W. Smith, Secretary, 414 Samaritan Avenue, Ashland 44805. 1st Thursday monthly.

ERIE—Clinton F. Lavender, President, 1218 Cleveland Road, Sandusky 44870; Mrs. David Wolfert, Executive Secretary, 1428 Hollywood Road, Sandusky 44870.

HOLMES—Charles H. Hart, President, 109 South Clay Street, Millersburg 44654; William A. Powell, Secretary, 8 West Adams Street, Millersburg 44654. 3rd Thursday monthly.

HURON—W. R. Graham, President, 15 Main Street, Wakeman 44889; E. R. McLoney, Secretary, 257 Benedict Avenue, Norwalk 44857. 2nd Wednesday of February, April, June, August, October, and December.

LORAIN—Joseph A. Cicerrella, President, 209 6th Street, Lorain 44052; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly except June, July and August.

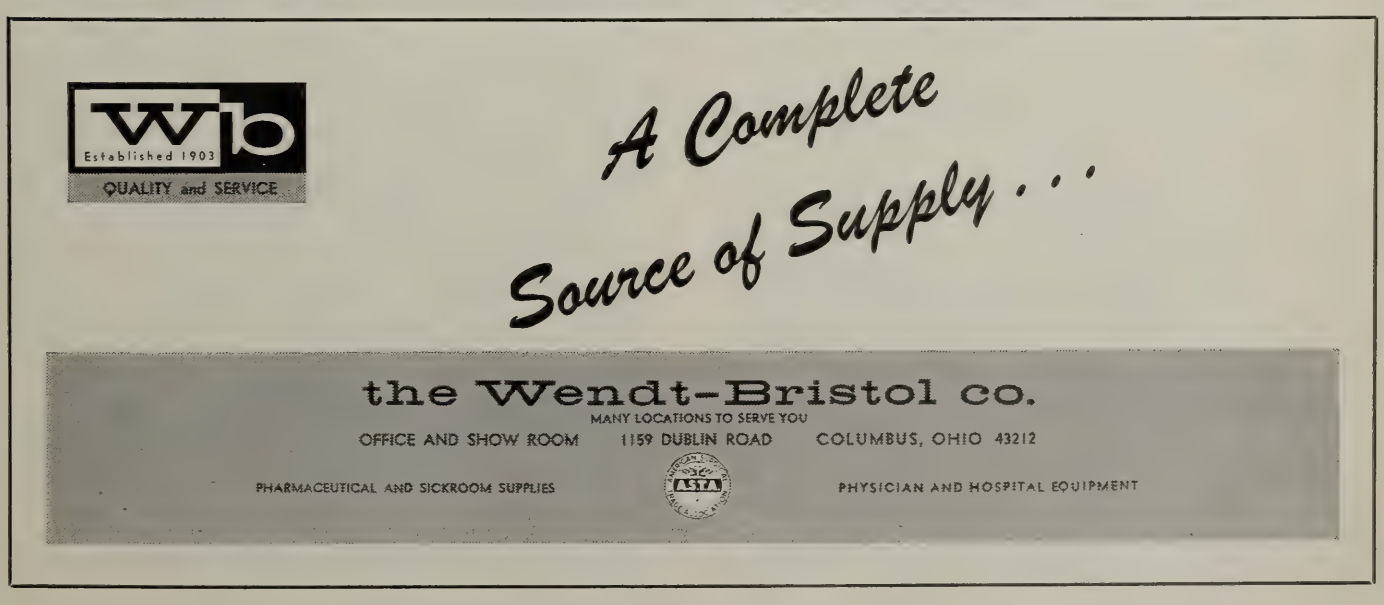
MEDINA—Myrl A. Nafziger, President, Albrecht Building, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina, Ohio 44256. 3rd Thursday monthly.

RICHLAND—C. J. Shamess, President, 74 Wood Street, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903. 3rd Thursday monthly except June, July, and August.

WAYNE—Howard MacMillan, President, 1740 Cleveland Road, Wooster 44691; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday monthly, January, February, April, September, November and December.

The Council for High Blood Pressure Research has named Dr. Irvine H. Page, Cleveland, editor-in-chief of a coming comprehensive textbook on renal hypertension. Already well advanced, the project includes contributions from authorities the world over. Dr. James McCubbin and other Cleveland physicians are working on the text.

At a meeting in Cleveland sponsored by the graduate chapter of the Newman Apostolate, three physicians discussed ethical questions involved in treating patients by methods not yet wholly approved by the profession. They were Drs. Joseph M. Foley and Robert J. White, professors of neurology, and Allen C. Moore, director of research, Western Reserve University.



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OSMA Members Not Required to Sign Nondiscrimination Pledge For Welfare Billing

Members of the Ohio State Medical Association no longer will be required to sign a pledge that they have complied with nondiscrimination provisions of the Civil Rights Act in order to bill for services to welfare patients. After some 16 months of efforts by OSMA, the Department of Health, Education, and Welfare has recognized the *Principles of Medical Ethics* as evidence of nondiscrimination.

OSMA's position has been that members of the Association pledge adherence to the *Principles of Medical Ethics,* and the *Principles* preclude discrimination.

The Department of Health, Education, and Welfare has accepted OSMA's position upon assurance that if and when charges of discrimination are preferred, disciplinary procedures will be set in motion and followed through as for other violations of the *Principles.*

Physicians who are not members of the Association must sign a pledge or enter a nondiscrimination statement on their fee bills.

Dr. Ralph J. Frackelton, Lakewood, addressed the Lakewood Historical Society on the topic "Great Moments in Medicine."

Usual Tax Roundup for Physicians Will Be Published in January

Due to unforeseen circumstances beyond control of *The Journal* staff, the Annual Tax Roundup for Physicians does not appear in this issue. It will be rescheduled for the January number.

Parts of the article pertaining to federal income taxes and social security taxes were sent to the Cincinnati office of the Internal Revenue Service for final review before publication. Because of pending minor changes in regulations, that office was not able to return the text to Columbus before publication deadline.

Paul A. Schuster, District Director of Internal Revenue at Cincinnati, and executive personnel in his office have been most cooperative with *The Journal* staff in reviewing tax articles this year and in previous years. The staff also has had valuable assistance and advice from that office. Only pending changes brought about a delay this year.

Watch for the January issue and valuable information on several categories of tax laws under which most physicians must file returns and pay taxes.

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